

STANDARD HEALTH EXAMINATION RECORD

(THIS SIDE TO BE FILLED IN BY PARENT AND REVIEWED WITH PHYSICIAN AT THE TIME OF EXAMINATION)

ORGANIZATION OR SCHOOL _____

NAME _____ PARENT OR GUARDIAN _____ PHONE _____
 LAST FIRST INITIAL

ADDRESS _____ DATE OF BIRTH _____ AGE _____ SEX _____
 STREET CITY ZIP CODE

IN EMERGENCY NOTIFY _____ ADDRESS _____ PHONE _____

HEALTH HISTORY (CHECK)

DISEASES	ALLERGIES	CHRONIC OR RECURRING ILLNESS
CHICKEN POX _____	HAY FEVER _____	EAR INFECTIONS _____
MEASLES _____	ASTHMA _____	HEART DISEASE _____
GERMAN MEASLES _____	DRUGS _____	CONVULSIONS _____
MUMPS _____	INSECT STINGS _____	DIABETES _____
	IVY, OAK, ETC. _____	BEHAVIOR _____
	FOOD _____	OTHER _____

SUGGESTIONS FROM PARENTS

OPERATIONS OR SERIOUS INJURIES (DATES) _____

HOSPITALIZATIONS _____

OTHER DISEASES OR DETAILS OF ABOVE _____

COMMENTS WHERE APPLICABLE (CAMPS OR BOARDING SCHOOL)

FAINTING _____ SLEEP DISTURBANCES _____ BED WETTING _____
 CONSTIPATION _____ OTHER _____

SPECIFIC ACTIVITIES TO BE ENCOURAGED _____

RESTRICTED _____

SPECIAL MEDICAL OR DIETARY REGIMEN TO BE CONTINUED (SPECIFY) _____

(OVER)

IMMUNIZATIONS

IMMUNIZATIONS	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
D.T.P.	_____	_____
DIPHTHERIA	_____	_____
TETANUS	_____	_____
WHOOPING COUGH	_____	_____
ORAL POLIO	_____	_____
MEASLES	_____	_____
SMALL POX	_____	_____
MUMPS	_____	_____
OTHER	_____	_____
TUBERCULIN TEST	TYPE _____	YEAR LAST GIVEN _____
		RESULT _____

PHYSICIAN'S COMMENTS AND RECOMMENDATIONS
 GIVE DETAILS OF MANAGEMENT OF SIGNIFICANT ILLNESSES

THIS PERSON IS IN SATISFACTORY CONDITION AND MAY ENGAGE IN ALL USUAL
 ACTIVITIES EXCEPT AS NOTED.

_____ M.D.

STREET _____

CITY _____ STATE _____ ZIP _____

PHYSICAL EXAMINATION

AN EXAMINATION FOR SOME OTHER PURPOSE WITHIN THE PAST SIX MONTHS IS
 ACCEPTABLE.

DATE OF EXAMINATION _____

CODE: SATISFACTORY _____ ✓
 NOT SATISFACTORY _____ X
 NOT EXAMINED _____ 0

HEIGHT _____ WEIGHT _____ B.P. _____

APPEARANCE NUTRITION _____

	WITHOUT GLASSES	WITH GLASSES
EYES	R 20/ _____ L 20/ _____	R 20/ _____ L 20/ _____

EARS _____ HEARING R _____
 L _____

NOSE _____

THROAT _____

TEETH _____

HEART _____

LUNGS _____

ABDOMEN _____

GENITALIA _____

HERNIA _____

SKIN _____

MUSCULOSKELETAL _____

URINALYSIS _____ HGB _____

OTHER NOTES _____