

Physician's Student Health Form

PHYSICIAN TO COMPLETE THIS FORM

Name of Student _____

Weight _____ lbs Height _____ in B/P _____

TB Risk Assessment: ☐ No Risk ☐ Positive, referral

Activity Restrictions: ☐ None ☐ Yes (specify)

2026-2027

The Shlenker School
Fax: 713-270-6114



VACCINE	DATE	DATE	DATE	DATE	DATE
DTap, DPT, DT, Td, Tdap					
Polio					
Measles, Mumps, Rubella (MMR)					
Haemophilus Influenza B (HIB)					
Hepatitis B					
Varicella (chicken pox)					
Hepatitis A					
Pneumococcal Conjugate					
Influenza (list type if known)					
Roto Virus (circle or designate Rotorix or RotoTec)					
Other (Meningococcal, TB, HPV, etc.)					
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Date of Last Physical* ____/____/____

Medication: Child take medicine for specific health condition(s):

Please note: If to be administered at school, write Rx here or attach! Be specific.

Special Diet* ☐ None ☐ Yes (specify)

Behavioral Issues/Mental Health Concerns*

Special Needs, Modifications, Special Equipment (please specify)*

Individualized Healthcare Plan (IHP) Needed*

(For example, emergency management of severe allergy, asthma, diabetes, seizure disorder, etc.)

Summary of findings:

- ☐ Well child—no conditions identified of concern to school program or activities.
☐ Conditions identified that are important to schooling or physical activity (specify).

***REQUIRED**

Health Care Professional's Certification: I certify that on this date, I have examined the above student and noted any limitations in participation, their current medical status, special needs, and immunizations of record.

Physician's Name _____ Physician's Signature _____ Date _____