

SCHOOL HEALTH RECORD

To be completed by Physician:

Name _____ Age: _____ Date: _____
(Last) (First)

HEALTH CONDITIONS

Y/N TB Skin Test Given: Negative _____ Positive _____ Date: _____

Heart Condition _____ Seizure Disorder _____
 Asthma _____ Diabetes _____
 Allergies _____ Other _____
 Significant Health History _____

Height _____ Weight _____ B.P. _____ Respiration _____ Pulse _____

Immunizations up-to-date: _____ Yes _____ No If no, reason _____

Physical Education and Activity Recommendations:
 _____ Full activity
 _____ Full activity without competitive sports
 _____ Full activity under close supervision
 _____ Limited activity, specify: _____

On Medication? _____
 Date of Examination: _____

 Physician's Signature

 Physician's Name (Print)

 Physician's Phone Number

To be completed by School District:

Grade		K	1	2	3	4	5	6	7	8	9	10	11	12
Vision	Right Eye													
	Left Eye													
Hearing	Right													
	Left													

KEY: N=Normal A=Audiogram O=Otologic *Vision screened with glasses _____

<u>Date</u>	<u>Recommendations and Comments</u>
Scoliosis Referral	Date: _____

Notes: