

# St. Patrick's Catholic School

## Health Examination Form

Last Name	First Name	Birth date	(M) (F) Sex
Address		Phone	Grade
Parent or Guardian's Name		Health Care Provider (please print)	

**Immunizations** (obtain a copy of the immunization record if possible)

<p>Immunization Month/Day/Year</p> <p>DTaP 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p> <p>4 _____/_____/_____</p> <p>5 _____/_____/_____</p> <p>Td 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p> <p>Tdap 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>VZV 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>Disease date year _____</p> <p>HPV 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p>	<p>Immunization Month/Day/Year</p> <p>Polio 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p> <p>4 _____/_____/_____</p> <p>5 _____/_____/_____</p> <p>MMR 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>HIB 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p> <p>4 _____/_____/_____</p> <p>Pevnar 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p> <p>4 _____/_____/_____</p> <p>Meningococcal 1 _____/_____/_____</p>	<p>Immunization Month/Day/Year</p> <p>Hep B 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>3 _____/_____/_____</p> <p>Hep B 2 dose series 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>Hep A 1 _____/_____/_____</p> <p>2 _____/_____/_____</p> <p>Influenza 1 _____/_____/_____</p> <p>Most recent</p> <p>Other Immunizations-Please list</p> <p>_____/_____/_____</p> <p>_____/_____/_____</p> <p>_____/_____/_____</p> <p>_____/_____/_____</p> <p>TB skin test result</p> <p>If indicated _____/_____/_____ Pos/Neg</p>
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**Health History** Check any past or present illness of this child the school should be made aware of, such as

Comments	Comments
____ Allergies: specify _____	____ Kidney disease/infections _____
____ Asthma _____	____ Physical handicaps _____
____ Cancer _____	____ Seizure disorder _____
____ Diabetes _____	____ Serious injuries _____
____ Fainting _____	____ Surgical operations _____
____ Heart disease _____	____ Other _____
____ Hepatitis _____	

What medication(s) is this child currently taking? \_\_\_\_\_ No \_\_\_\_\_ Yes

<u>Medication/indication</u>	<u>Dose/Frequency</u>

PLEASE COMPLETE BOTH SIDES

**Physical Examination**

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

General Appearance/Medical diagnosis \_\_\_\_\_

Labs: Hgb or Hct \_\_\_\_\_ Lead level drawn Y/N result \_\_\_\_\_ Urinalysis \_\_\_\_\_

Recent Dental Exam Date \_\_\_\_\_

	Normal	Abnormal	Comments
Scalp/Skin	_____	_____	_____
Lymph Nodes	_____	_____	_____
Head/Neck	_____	_____	_____
Ears/Nose/Throat	_____	_____	_____
Mouth/Teeth/Gums	_____	_____	_____
Speech	_____	_____	_____
Heart (rate/rhythm)	_____	_____	_____
Lungs (respiratory rate)	_____	_____	_____
Abdomen	_____	_____	_____
Extremities	_____	_____	_____
Neurological status	_____	_____	_____
Musculo-Skeletal (scoliosis)	_____	_____	_____
Mental development	_____	_____	_____

Is this child subject to any conditions which limit: Classroom activities? Yes ( ) No ( )  
 Physical education? Yes ( ) No ( )  
 Competitive sports? Yes ( ) No ( )

If yes, please describe: \_\_\_\_\_

Do you feel this child needs further evaluation or referrals? Yes ( ) No ( )

If yes, please describe: \_\_\_\_\_

**Hearing Screening** \_\_\_\_\_ Pass \_\_\_\_\_ Fail Referral \_\_\_\_\_  
 Audio Test 500 Hz 1000Hz 2000Hz 4000Hz  
 Right Ear---dBHL  
 Left Ear---dBHL

**Vision Exam (Required for Kindergarten and students transferring from outside of NE)**

Test	Negative	Positive	Recommend Further Examination (See comments below)
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Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____

	Normal	Abnormal	
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____

Visual Acuity Right: 20/\_\_\_\_\_ Left: 20/\_\_\_\_\_ Both: 20/\_\_\_\_\_  
 \_\_\_\_\_ without correction \_\_\_\_\_ with correction

Comments/Recommendations: \_\_\_\_\_

\_\_\_\_\_  
Date of Exam

\_\_\_\_\_  
Signature of Licensed Health Care Provider

\_\_\_\_\_  
Office Phone #