



### Student Health Appraisal

\* Required for all new students and annually through age seven for all others\*

**INFORMATION MAY BE SHARED WITH STAFF ON A NEED-TO-KNOW BASIS**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Section A:** (to be completed by parent before physical examination)

Check all that apply and **provide details below:**

- |   |   |
|---|---|
| <input type="checkbox"/> Seasonal allergies                 | <input type="checkbox"/> Frequent Colds     |
| <input type="checkbox"/> Life threatening allergy           | <input type="checkbox"/> Hearing difficulty |
| <input type="checkbox"/> Other allergies                    | <input type="checkbox"/> Speech difficulty  |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Visual difficulty  |
| <input type="checkbox"/> Constipation/Diarrhea (circle one) | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Physical handicap  |

**Please provide details of above or any additional information:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Section B:** (to be completed by physician or nurse practitioner)

**Date of physical exam:** \_\_\_\_\_

Please note abnormal findings in any of the following areas and elaborate below (X = within normal limits):

- |                                       |  |                                    |
|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Scalp/Skin   | <input type="checkbox"/> Throat/Tonsils    | <input type="checkbox"/> Lungs     |
| <input type="checkbox"/> Eyes/Vision  | <input type="checkbox"/> Teeth/Mouth       | <input type="checkbox"/> Abdomen   |
| <input type="checkbox"/> Ears/Hearing | <input type="checkbox"/> Neck              | <input type="checkbox"/> Genitalia |
| <input type="checkbox"/> Nose/Smell   | <input type="checkbox"/> Glands            | <input type="checkbox"/> Height    |
| <input type="checkbox"/> Neuro        | <input type="checkbox"/> Heart/Circulation | <input type="checkbox"/> Weight    |

**Details of abnormalities or recommendations:** \_\_\_\_\_

**Lead level:** \_\_\_\_\_ **Date tested:** \_\_\_\_\_ **(Blood lead level *required* in DE @ 1 year of age.)**

**TB screening date:** \_\_\_\_\_ **Low risk per questionnaire** - or - **PPD** \_\_\_\_\_ **mm**

DTaP 1 -	DTaP 2 -	DTaP 3 -	DTaP 4 -	DTaP 5 -
IPV 1 -	IPV 2 -	IPV 3 -	IPV 4 -	Varicella 1 -
Hib 1 -	Hib 2 -	Hib 3 -	Hib 4 -	Varicella 2 -
MMR 1 -	MMR 2 -	Hep B 1 -	Hep B 2 -	Hep B 3 -

**Examiner's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_