



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: _____ X = within normal limits

Please note abnormal findings in any of the following areas and elaborate below:

- | | | |
|---------------------------------------|--|------------------------------------|
| <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: _____

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 -
*Lead -	Lead results -	PPD -	PPD results <u>or</u>	No PPD – low risk

Examiner's Signature: _____ Date: _____

Printed Name: _____ Telephone: _____

* Lead level is required in DE @ age 1 year; "low risk" is not acceptable. Please specify date and results.