

School Health Examination Record

Grade: _____

I. Child's Name

Last	First	Middle	Birth Date	Home Address	Phone
Father 's or Guardian's Name		Place of Employment			Business Phone
Mother's or Guardian's Name		Place of Employment			Business Phone
Physician's Name		Address			Office Phone

II. Is there anything about your child that the teacher needs to know to understand him/her better?

III. List diseases and other serious illnesses, injuries, or health conditions your child has had and give dates (year only):

IV. Does any relative or anyone in the home have tuberculosis, diabetes, or other illnesses? Describe:

DENTIST'S REPORT (Optional)

Child's Name: _____

PHYSICIAN'S REPORT

The following services have been performed:

(Please Check)

- _____ Radiographs
- _____ Oral prophylaxis
- _____ Fluoride treatment
- _____ Restorations

The following statements are applicable:

(Please Check)

- _____ All necessary services have been performed.
- _____ No restorative services are required at this time.
- _____ Further treatment is indicated.
- _____ Future appointments have been arranged.

COMMENTS:

Date: _____

Signature of examining dentist

IMMUNIZATIONS					
Fill in Mo/Day/Yr	Date	Date	Date	Date	Date
DPT					
Td or DT					
Polio					
Prevnar					
MMR					
Hepatitis B					
Varicella					
HIB					
Other					

Screening Tests			
	Date	Result	
Muscle Balance			
Color			
Distance Acuity		Right	Left
Hearing			

	Date	Test	Result
Tuberculin			

PHYSICAL ASSESSMENT

Check one:

- _____ Entirely within normal limits
- _____ Abnormalities as follows:

Above student is free from communicable disease, including tuberculosis, verified either through negative skin test or negative chest X-ray, and has had immunizations required by statute for admission to school under Section 3313.671 of the Revised Code.

Is there any reason why the student cannot carry out a full program of school work?

Yes _____ No _____

Date of Exam: _____

Signature of examining physician