STUDENT HEALTH EXAMINATION FORM

Westside Community Schools — Office of Student Services

Please Print Clearly

TO BE COMPLETED BY PARENT OR GUARDIAN

Student's Last Name	Student's First Name	Middle Initial	Gender ☐ Male ☐ Female	Date of Birth _____/_____/______
Child's Address	City		State	ZIP
School Name			Grade Level	Home Phone
Parent Last Name	First Name	Relationship to Student		Parent Cell/Day Phone

TO BE COMPLETED BY HEALTH CARE PROVIDER

If checking any item, please explain (attach addendum, if needed)

Allergies ☐ None ☐ EpiPen prescribed

☐ Drugs (list) ____

☐ Foods (list) ____

☐ Other (list) ____

Medications ☐ None ☐ Yes (list below)

Dietary Restrictions ☐ None ☐ Yes (list below)

Does the child/adolescent have a past history of or currently exhibit any of the following?

☐ Asthma (check severity and attach Medical Authorization Form/Asthma Action Plan)

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Concussion (If Yes, Year ________)
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach Medical Authorization Form)
☐ Orthopedic injury/disability
☐ Seizure disorder (Attach Seizure Action Plan)
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Other *(specify)* ____________________

Explain all checked items:

PHYSICAL EXAMINATION

Height _____________ (____%ile)

Weight _____________ (____%ile)

BMI _____________ (____%ile)

Blood pressure _________/__________

General Appearance

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin	☐ ☐ Psychosocial Development
☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological	☐ ☐ Language
☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/Spine	☐ ☐ Behavioral

Describe Abnormalities:

DEVELOPMENTAL

If delay suspected, specify below

☐ Cognitive (e.g., play skills) ______________________________

☐ Communication/Language ___________________________

☐ Social/Emotional ___________________________________

☐ Adaptive/Self-Help ________________________________

☐ Motor ____

Comments:

SCREENING TESTS

Tuberculin Skin Test

☐ Positive ☐ Negative

Hemoglobin or Hematocrit

___/___/___ ______g/dL _____%

Vision Test

Amblyopia	☐ Pass	☐ Fail
Strabismus	☐ Pass	☐ Fail
Internal Eye Health	☐ Pass	☐ Fail
External Eye Health	☐ Pass	☐ Fail

Visual Acuity	Right	Left	Both
With Glasses	20/	20/	20/
Without Glasses	20/	20/	20/

Hearing Test ☐ Pass ☐ Fail

Audio Test	500	1000	2000	4000
Right Ear				
Left Ear				

IMMUNIZATIONS — DATES

Hep B	___/___/___ ___/___/___ ___/___/___
DTP/Td	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Tdap	___/___/___
Polio (oral)	___/___/___ ___/___/___ ___/___/___ ___/___/___
Varicella	___/___/___ ___/___/___ Date of disease _______________
MMR	___/___/___ ___/___/___ ___/___/___
Other	___/___/___ ___/___/___ ___/___/___
Other	___/___/___ ___/___/___ ___/___/___

RECOMMENDATIONS

☐ Restrictions (specify) ____

Follow-up Needed ☐ No ☐ Yes, for __________________ Appt. Date: ___/___/___

Referral(s): ☐ None ☐ Dental ☐ Vision ☐ Early Intervention ☐ Special Education

☐ Other ____

ASSESSMENT

☐ Well Child ☐ Diagnoses/Problems (list):

Health Care Provider Signature			Date	
Health Care Provider Name and Degree (print)			Facility Name	
Address	City	State	ZIP	Telephone