Student Name: _____
DOB: _____

This portion is completed by the health care provider

Ht _____ (inches)

Wt _____ (pounds)

Blood Pressure _____
Lead screening results _____
_____
_____
Vision screening, if eye exam not scheduled
Right _____ Left _____
Glasses-At all times/Reading/Distance only
Hearing screening
Right _____ Left _____

General appearance
_____
_____

Skin _____ Eyes _____ Ears _____
Nose _____ Mouth _____
Throat _____ Teeth _____
Respiratory _____
Cardiovascular _____
Gastrointestinal _____
Genitourinary _____
Muscular/Skeletal _____
Neurological _____

Comments: _____

_____

Does child see a dentist? ☐ **yes** ☐ **no** Does child have dental health concerns? ☐ **yes** ☐ **no**

Does this child have a health concern which may require an EMERGENCY ACTION PLAN while s/he is at school? Attach a plan printout please. (e.g. seizure disorder, diabetes Type 1 or 2, cardiac issue , asthma, bleeding issue, insect sting allergy, severe food allergy) ☐ **yes** ☐ **no**

List any allergies and specific reactions.

Are any allergies LIFE-THREATENING? ☐ **yes** ☐ **no**
If yes, please describe.

Does student need an epinephrine auto injector?** ☐ **yes** ☐ **no**

Is this student on daily medication? ☐ **yes** ☐ **no**
If yes, please list medication, dosage and frequency.**

Are there any restrictions of physical activity or physical education in school? ☐ **yes** ☐ **no**
If yes, please describe nature, duration and any special equipment used.

Does student need special nutritional consideration? ☐ **yes** ☐ **no**
If yes, please describe.

Are there any other significant findings on exam, family or health history that may impact this child's health or learning at school? ☐ **yes** ☐ **no**

****A Medication Request/Consent Form must be completed in order for school staff to administer medication at school.**

Signature/title of health examiner: _____ Date: _____

Printed or typed name of examiner: _____

Address of examiner: _____ Phone number: _____