HEALTH APPRAISAL

Parent or Legal Guardian fills out front of this form. Child's physician must fill our and sign the back of this form.

Child's name (last, first, middle)			
Address			City & Zip code
Date of Birth	Male	Female	Today's date:
Parent/Guardian's name			
Home phone number			Work and or cell phone numbers

Section 1 - Health History

Is your child having any of the problems listed below	Yes	No
Allergies or reactions (for example food, medications or other)		
Hay fever, asthma or wheezing		
Eczema or frequent skin rashes		
Convulsions/ seizures		
Heart Trouble		
Diabetes		
Frequent colds, sore throat, earaches (4 or more per year)		
Trouble with passing urine or bowel movements		
Shortness of Breath		
Speech problems		
Dental problems		
Other?		
Does your child take any medications regularly?		

Please explain any "Yes" answers listed above:

Section 2 - Immunization record

Vaccine	Date Given	Date Given
DTaP/DTP/Td	1	4
DTaP/DTP/Td	2	5
DTaP/DTP/Td	3	6
MMR	1	2
POLIO/OPV/IPV	1	3
POLIO/OPV/IPV	2	4
Hepatitis B HBV	1	3
Hepatitis B HBV	2	4
Varicella	1	2
HIB	1	3
HIB	2	4
Pneumococcal Conjugate	1	3
Pneumococcal Conjugate	2	4
Other Vaccines:		
Other Vaccines:		

Parent Signature	Validating Signature

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Section 3- Physical Examination, tests and measurements

Tests and Measurements	normal	Under care	
Vision Tested? Y / N date:			_____Visual activity _____Ocular Muscle _____Other
Hearing Tested? Y / N date:			_____Audiometer _____Other
Urinalysis Done? Y / N date:			_____Sugar _____Albumin _____Microscopic
Hemoglobin tested? Y / N			
Blood lead level tested? Y / N			Level _____ug/dl
Blood pressure reading:			Height: Weight:

Tuberculin test (if given) Date: Type: Positive / Negative (circle one)

Essential findings deviating from normal and/or recommendations:

Section 4 - Recommendations

Is there any defect of vision, hearing or other condition for which further help or action is needed? Yes / No

Should this student's activity be restricted in any way due to any physical defect or illness? Yes / No

If yes was answered to either of the above questions, please explain:

Examiner's signature:	Date:
Print Examiner's Signature	Degree/License
Address	Phone number

Section 5 - Dental examination and recommendations (optional)

I have examined _____and I make the following recommendations:

Dentist's Signature:	Date: