

HEALTH FORM

2010-2011

Student _____ DOB _____ Grade/Form _____

***IMMUNIZATION DATES**

Hep B or hep B/HIB	D/ P/ T DTaP or DTP	Polio OPV or IPV	Measles / Mumps / Rubella	HIB	OTHER:
1.	1.	1.	MMR 1	1.	HEP A 1.
2.	2.	2.	MMR 2	2.	2.
3.	3.	3.		3.	INFLUENZA
	4.	4.	Measles		
			Mumps		HAD Varicella disease?
	Tdap		Rubella		No Yes-date
					VARIVAX 1.
	Td				2.

***For New Students Only**

Physical Exam:

PPD Mantoux: Required for any student NEW to NYC schools.
Is student NEW to NYC schools? Yes / No (circle)

Height: _____ (___ %) Weight: _____ (___ %) BMI _____ (___ %)

Pulse _____ Resp. _____ B/P _____ / _____

Date	Results/mm	X-ray

Vision Screening Date: _____
Right _____ Left _____

Auditory Screening Date: _____

Right Pass Fail
Left Pass Fail

Check each line	Normal	Abnormal	Follow-up	Omitted
General				
Skin/Scalp				
HEENT				
Neck				
Lungs				
Heart				
Abdomen				
Musculoskeletal/Scoliosis				
Neurological				
Endocrine				
Genitalia/Tanner Stage				
Psychosocial				
Nutrition				
Dental				

Allergies:
Epi-Pen Prescribed: Yes* <i>Check Below</i> No
ASTHMA: Yes No Active Resolved
Age of Onset: Last Episode(year): Peak Flow=
Asthma Medications: **MDI: <i>Check Below</i>
History of Illness / Surgery / Medication:

*******RESTRICTIONS / INSTRUCTIONS*******

Please list any physical activities that you would recommend that the student refrain from participating in.

CLEARED TO PARTICIPATE IN GYM AND SPORTS: YES NO **NOTE ANY RESTRICTIONS ABOVE

Please check to indicate your instructions.

Yes NO Asthma: Student may carry and self-administer Metered Dose Inhaler LISTED ABOVE in Asthma section.**

Yes NO Epi-Pen: Provided by student. Prescribed for anaphylaxis to a specific KNOWN allergy, listed above.**

**Separate Medication Administration form or Food Allergy Action plan needs to be completed by MD and parent.

Medical Provider Signature _____ Exam Date _____

OFFICE STAMP: (MUST ACCOMPANY SIGNATURE)