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 additional sheet, 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 _____ (REQUIRED) (____%ile)

Weight _____ (REQUIRED) (____%ile)

BMI _____ (____%ile)

Blood pressure _____/_____

General Appearance

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

Vision Test (REQUIRED)

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

Visual Acuity

20 feet: Right 20/____ Left 20/____ Both 20/____ ☐ with glasses ☐ without glasses

Hearing Test ☐ Pass ☐ Fail

Audio Test	500	1000	2000	4000
Right Ear				
Left Ear				

IMMUNIZATIONS — DATES (REQUIRED)

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

Form Updated 2018