SCHOOL HEALTH EXAMINATION RECORD

Child's Name_____ Date of Birth_____

Parent/Guardian_____ Address_____

Immunizations given to date.

	1st dose	2nd dose	3rd dose	4th dose	5th dose
DPT/DT					
Hib					
Polio					
Hepatitis B					
MMR					
Chickenpox					

Please fill in month/day/year.

Or date of chickenpox disease_____

Allergies:
Asthma:

Height	Weight	Hearing		Vision		Blood Pressure
		Right	Left	Right	Left	
				Corrective Lenses: Yes No		

Findings	Normal	
		Neuro-Musc. System
		Orthopedic
		Nutrition
		Skin and Scalp
		Nose
		Throat and Mouth
		Eyes
		Ears
		Glands
		Heart
		Lungs
		Abdomen
		Genitalia
		Urinary
		Blood Count

FINDINGS:

MEDICATIONS TAKEN REGULARLY:

Any meds to be taken at School: Yes No (If yes, please write note for school)

CONDITIONS WHICH COULD AFFECT SCHOOL WORK:

Signature of Physician_____ Date_____

8/09dku (SCHOOL01) **GRANT COUNTY HEALTH DEPARTMENT**
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