Student Health History and Physical Examination

Student's Name: ____ **DOB:** ________________ ☐ **M** ☐ **F**

Address: ____ **SCHOOL** ______________ **GRADE** ___

Hospitalizations/Surgery: ____

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____

Medications: ____

Ht: ______________ **Wt:** ________________ **BMI:** _______________ **BP:** ________/__________

Vision: R____/____ **L**____/____ **Hearing:** ____________ **Scoliosis:** ☐ **Yes** ☐ **No**

Allergies: Foods____________________________________ Meds ___________________________________
Other ______________________________________ Anaphylaxis ______________EPI pen ☐ Yes ☐ No

Asthma: ☐ Active ☐ Inactive ☐ Asthma Action Card® **Diabetes**: ☐ Type 1 ☐ Type 2 ☐ Pump

	WNL	ABNORMAL: comments
Skin		
Skeletal		
HEENT		
Neck		
Lung		
Heart		
Abd/ GI		
GU		
Neuro		

Impression: ____
____

☐ **Full Physical Activity**

☐ **Restricted Physical Activity**

Vaccine	1st	2nd	3rd	4th	5th
DTaP					
Tdap					
OPV/IPV					
MMR					
Hib					
HepB					
HepA					
Varicella					
Meningococcal					
Pneumococcal					
HPV					

PPD:
Date administered:________
Results: ___________ mm
CXR: ____ **Prophylaxis:** ____

☐ **Varicella Disease**:
Date:____________________

STAMP

Physician Signature ___________________________________ **Date** ____________

Address: ____