

STANDARD HEALTH EXAMINATION RECORD

(THIS SIDE TO BE FILLED IN BY PARENT AND REVIEWED WITH PHYSICIAN AT THE TIME OF EXAMINATION)

ORGANIZATION OR SCHOOL _____

NAME _____ PARENT OR GUARDIAN _____ PHONE _____
LAST FIRST INITIAL

ADDRESS _____ DATE OF BIRTH _____ AGE _____ SEX _____
STREET CITY ZIP CODE

IN EMERGENCY NOTIFY _____ ADDRESS _____ PHONE _____

HEALTH HISTORY (CHECK)	ALLERGIES	CHRONIC OR RECURRING ILLNESS
DISEASES		
CHICKEN POX _____	HAY FEVER _____	EAR INFECTIONS _____
MEASLES _____	ASTHMA _____	HEART DISEASE _____
GERMAN MEASLES _____	DRUGS _____	CONVULSIONS _____
MUMPS _____	INSECT STINGS _____	DIABETES _____
	IVY, OAK, ETC. _____	BEHAVIOR _____
	FOOD _____	OTHER _____
OPERATIONS OR SERIOUS INJURIES (DATES) _____		
HOSPITALIZATIONS _____		
OTHER DISEASES OR DETAILS OF ABOVE _____		

SUGGESTIONS FROM PARENTS

COMMENTS WHERE APPLICABLE (CAMPS OR BOARDING SCHOOL)

Fainting _____ Sleep Disturbances _____ Bed Wetting _____

Constipation _____ Other _____

Specific Activities to be Encouraged _____

Restricted _____

Special Medical or Dietary Regimen to be Continued (Specify) _____

(OVER)

IMMUNIZATIONS

IMMUNIZATIONS	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
D.T.P.	_____	_____
DIPHTHERIA	_____	_____
TETANUS	_____	_____
WHOOPIING COUGH	_____	_____
ORAL POLIO	_____	_____
MEASLES	_____	_____
SMALL POX	_____	_____
MUMPS	_____	_____
OTHER	_____	_____
TUBERCULIN TEST	TYPE _____ YEAR LAST GIVEN _____	RESULT _____

PHYSICIAN'S COMMENTS AND RECOMMENDATIONS
 GIVE DETAILS OF MANAGEMENT OF SIGNIFICANT ILLNESSES

THIS PERSON IS IN SATISFACTORY CONDITION AND MAY ENGAGE IN ALL USUAL ACTIVITIES EXCEPT AS NOTED.

 STREET _____
 CITY _____ STATE _____ ZIP _____

PHYSICAL EXAMINATION

AN EXAMINATION FOR SOME OTHER PURPOSE WITHIN THE PAST SIX MONTHS IS ACCEPTABLE.

DATE OF EXAMINATION _____

CODE: SATISFACTORY ✓
 NOT SATISFACTORY X
 NOT EXAMINED 0

HEIGHT _____ WEIGHT _____ B.P. _____

APPEARANCE NUTRITION _____

EYES _____	WITHOUT GLASSES	WITH GLASSES
	R 20/ _____ L 20/ _____	R 20/ _____ L 20/ _____

EARS _____ HEARING R _____ L _____

NOSE _____

THROAT _____

TEETH _____

HEART _____

LUNGS _____

ABDOMEN _____

GENITALIA _____

HERNIA _____

SKIN _____

MUSCULOSKELETAL _____

URINALYSIS _____ HGB _____

OTHER NOTES _____