

HEALTH EXAMINATION FORM

To participate in sports teams, please complete the Athletic Pre-Participation Physical Evaluation Form in addition to this form

Child's Last Name	First Name	Middle Name	<input type="checkbox"/> Female	<input type="checkbox"/> Male	Date of Birth (Month/Day/Year)
Child's Address					
City		State		Zip Code	
PHYSICAL EXAMINATION Height _____ Weight _____ BMI _____ Blood Pressure ____/____			GENERAL APPEARANCE NI Abnl <input type="checkbox"/> <input type="checkbox"/> HEENT <input type="checkbox"/> <input type="checkbox"/> Dental <input type="checkbox"/> <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> Lymph Nodes <input type="checkbox"/> <input type="checkbox"/> Extremities		
DATE OF LAST PHYSICAL EXAM: ____/____/____			NI Abnl <input type="checkbox"/> <input type="checkbox"/> Back/Spine <input type="checkbox"/> <input type="checkbox"/> Neck <input type="checkbox"/> <input type="checkbox"/> Skin <input type="checkbox"/> <input type="checkbox"/> Language <input type="checkbox"/> <input type="checkbox"/> Lungs		
			NI Abnl <input type="checkbox"/> <input type="checkbox"/> Genitourinary <input type="checkbox"/> <input type="checkbox"/> Cardiovascular <input type="checkbox"/> <input type="checkbox"/> Neurological <input type="checkbox"/> <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> <input type="checkbox"/> Behavioral		
DESCRIBE ABNORMALITIES: _____					
DOES THE CHILD/ADOLESCENT HAVE A PAST OR PRESENT MEDICAL HISTORY OF THE FOLLOWING: <input type="checkbox"/> Asthma (check severity & attach MAF/Asthma Action Plan) <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral Steriod <input type="checkbox"/> None					
<input type="checkbox"/> Attention Deficity Hyper Activity Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem		<input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Eating disorders <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Previous Surgery <input type="checkbox"/> Seizure		<input type="checkbox"/> Speech, hearing or visual impairment <input type="checkbox"/> Stomach/Intestinal disorder <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis, latent infection or disease <input type="checkbox"/> Other (Specify) _____	
Explain all checked items above or on addendum: _____					
Dietary Restrictions (please list): _____ <input type="checkbox"/> Lactose Intolerant					
Medications (attach MAF if in-school medication is needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (please list) _____					
SCREENING TESTS					
Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date: ____/____/____		Vision ____/____/____ <input type="checkbox"/> With Glasses Acuity Right ____/____ Left ____/____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes Date: ____/____/____		Scoliosis <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date: ____/____/____	
		Tuberculosis PPD/Mantoux placed Date: ____/____/____ PPD/Mantoux read Date: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Not Indicated			
RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____			ASSESSMENT <input type="checkbox"/> Well Child <input type="checkbox"/> Diagnoses/Problems (explain) _____ _____		
Health Care Provider (print)					
Facility Name					
Address		City		State	
				Zip	
Telephone			Fax		
Health Care Provider Signature			Date		

PLEASE ATTACH IMMUNIZATION RECORDS