Gretna Public Schools

Health Examination Form/Health History Form

Student Name: _____ **Date of Birth:** _____
Address: _____ **Phone #:** _____
Gender: _____ Male _____ Female **Current Grade:** _____
Name of Parent(s)/Guardian(s): _____
Name of School Attending: _____

Immunization Information (List Month/Day/Year)

DTaP,DTP,DT,DTAP	1 _____	2 _____	3 _____	4 _____	5 _____	6 _____
Polio	1 _____	2 _____	3 _____	4 _____		
MMR	1 _____	2 _____				
HIB	1 _____	2 _____	3 _____	4 _____		
Hepatitis B	1 _____	2 _____	3 _____	4 _____		
Varicella	1 _____	2 _____	and/or Date of Chicken Pox Disease _____			
Pneumococcal	1 _____	2 _____	3 _____	4 _____	5 _____	

Immunizations given today: _____

Physical Exam

Height _____ **Weight** _____ **Blood Pressure** _____/_____ **Pulse** _____

Vision Screening: Correction: Y N

Near Vision
Right Eye 20/___
Left Eye 20/___

Far Vision
Right Eye 20/___
Left Eye 20/___

Hearing Screening:
Audio Test 500 1000 2000 4000 Pass/Fail
Right Ear _____
Left Ear _____

	Normal	Abnormal	Comments
Nutritional Status	_____	_____	_____
Scalp/Skin	_____	_____	_____
Head/Neck	_____	_____	_____
Mouth/Teeth/Gums	_____	_____	_____
ENT	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Musculo-skeletal	_____	_____	_____
Posture/Scoliosis	_____	_____	_____
Neurological	_____	_____	_____

Additional Comments _____

_____

(over)

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List Allergies to:

Medications: _____ Environmental: _____
Food: _____ Insects: _____
Other: _____

Medications this student is taking (include dose and frequency): _____

_____

_____

Health Condition/Programs and Comment:

____ Headaches _____
____ Seizure Disorder _____
____ Eye/Vision Problems _____
____ Ear/Hearing Problems _____
____ Speech Problems _____
____ Heart Problems _____
____ Asthma/Other Lung Problems _____
____ Diabetes _____
____ Stomach Problems _____
____ Bowel/Bladder/Kidney Problems _____
____ Skin Problems _____
____ Physical Handicap _____
____ Behavior Problems _____
____ Learning Problems _____
____ Surgical Procedures _____

List any other illness/injury or health information: _____

_____

_____

Do any of the above conditions limit:

Classroom activities?	Yes _____	No _____
Physical Education?	Yes _____	No _____
Competitive Sports?	Yes _____	No _____

If yes, please describe: _____

_____

On the basis of this exam, does this student need further referral or evaluation? _____

_____

_____

_____ _____

Signature of Licensed Physician, Physician's Asst., Nurse Practitioner **Date of Exam**