Augusta School Department - School Health Examination

To Be Completed By Health Care Provider

Student Name _____ Date _____

Height: Weight: BMI Blood Pressure:

Urinalysis: Vision: Right: Left: Hearing: Right: Left:

Immunizations: Dates of initial series and boosters

DPT-DT:	MEASLES:
ORAL POLIO:	MUMPS:
TETANUS/TD/TDaP booster:	GERMAN MEASLES:
HIB:	or MMR #1 or MMR#2
Tuberculin Skin Test Type: Results:	Hepatitis B Series: #1 #2 #3
VARICELLA #1 #2	

Nutrition:	Heart:
Skin:	Lungs:
Eyes:	Abdomen:
Ears:	Hernia:
Nose:	Genitalia:
Throat:	Bone & Joints:
Teeth:	Scoliosis:

This student may participate in: Regular physical activity: Limited physical activity:

Interscholastic sports:

Remarks - Any medical concerns the school should be aware of.

_____

_____

_____

Signature of Health Care Provider

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For kindergarten, sixth and ninth grades and all new pupils. **Parents, please complete *before* examination.**

Please Print:

Student: Sex: M F Date Of Birth: / / Previous School

Grade: Address:

Parent/Guardian: Phone:

Current health concerns and medications now taking:

Please check, give date and describe any of the following that the child has had -

☐ Dizzy spells or seizure activity
caused by:

treatment: medication:

☐ asthma - medication
specify: treatment:

☐ allergies:

☐ diabetes - medication

☐ serious illness or injury (ies) - describe

☐ operations - describe

☐ frequent headaches - treatment

☐ frequent ear infections - treatment

☐ frequent stomachaches - treatment

☐ onset of menstruation - age Problems?:

☐ Medications taken regularly	type/name/dose/#of times taken:	

☐ fractures, sprains, dislocations

☐ Chicken pox, date:

I give permission for the exchange of information between the health care provider and the school nurse.

Signature of Parent/Guardian