B"H

Health History & Examination Form

STUDENT_____ BIRTH DATE_____/_____/_____ DATE OF EXAM_____/_____/_____

1. BP _____ Pulse
2. Height _____ Weight_____
   Body Mass Index: _____
   Weight Status Category (BMI Percentile)
   ❑less than 5th ❑5th- 49th ❑ 50th- 84th
   ❑85th -94th ❑95th 98th ❑99th and higher
3. Urinalysis_____
4. Heart _____
5. Breasts _____
6. Lungs _____
7. Eyes R _____ L_____
   With Glasses R_____ L _____
8. Visual Diagnosis _____
9. Ears: Otoscopic _____
   Audiometric_____
   P.E. tubes Yes _____No_____
10. Speech _____
11. Nose _____
12. Throat_____
13. Tonsils _____
14. Teeth and gums _____
15. Skin _____
16. Glands (cervical, thyroid, other) _____
17. Nervous system _____
18. Hernia
19. Genitourinary
20. Tanner I. II. III. IV. V.
21. Orthopedic: scoliosis: ❑ positive ❑ negative
    Posture _____ feet_____
    Structural defects _____
22. Abdomen _____

SURGERIES: _____

SIGNIFICANT ILLNESSES / INJURIES: _____

ALLERGIES: _____

CURRENT MEDICATIONS (please list all medications and dosages):_____

Are there any hearing, visual or dental conditions requiring special attention? ❑ Yes ❑ No

Are there any medical or developmental conditions requiring special attention? ❑ Yes ❑ No

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IMMUNIZATIONS *(please fill in or attach record of immunization)*

DPT or DTaP_____ (3 required)

Td or DT Booster_____

Tdap_____

Polio (OPV or IPV)_____/_____/_____ (3 required)

PCV ____/_____/_____/_____

MMR_____/_____ (2 measles required)

Varicella_____

HIB ____/_____/_____/_____

Hep B_____/_____/_____ (3 required)

Other _____

PROCEDURES / TESTS

TB Screening_____

Chest X-ray_____

Lead Screening_____

Sickle Cell Test _____

On the basis of my findings as indicated above and on my knowledge of named child, I find that:
he/she is free from contagious and communicable disease and is able to participate in child day care. ❑ Yes ❑ No

_____ Signature of Examining Physician

_____ Date

_____ Print Name

Physician's Address & Phone_____

(PLEASE STAMP)

Please Email this form.

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