

HEALTH EXAMINATION FORM

Brentwood Christian School

To Be Completed by the Doctor

NAME _____ DATE OF BIRTH _____ HT. _____ WT. _____

VACCINES	*Date	*Date	*Date	*Date	*Date	*Date
DTP/DTaP/DT/Td						
OPV, IPV**						
Measles						
Mumps and Rubella						
Hib CV						
Varicella						
Hepatitis A						
Hepatitis B						
Meningococcal						
TBC Test and Result:						

* month/date/year

** circle one

Comment in regard to these factors of child's GENERAL HEALTH:

- 1) Has this child: (Please explain any yes answers)
- a) had any chronic illnesses – i.e., Asthma, Diabetes, Cystic Fibrosis? Yes: _____ No: _____
 - b) had any allergies that require special attention or medication? Yes: _____ No: _____
 - c) had any past history of head injury, concussion, seizure, etc.? Yes: _____ No: _____
 - d) had any heart or blood pressure abnormalities? Yes: _____ No: _____
 - e) had any spinal injuries or spinal defects of any kind? Yes: _____ No: _____
 - f) had any need for medication at school? Yes: _____ No: _____
 - g) been exposed to tuberculosis? Yes: _____ No: _____
 - h) been subject to headaches? Yes: _____ No: _____
 - i) had any serious or significant accidents (give dates)? Yes: _____ No: _____
 - j) had any surgical procedures (give dates)? Yes: _____ No: _____
 - j) been prescribed corrective lenses (if so, date of last eye exam)? Yes: _____ No: _____
 - k) had any serious or significant dental needs? Yes: _____ No: _____
 - l) had the chicken pox (give date)? Yes: _____ No: _____

2) Are there any limitations for this child's participation in physical education, sports or school activities? _____

Vision Screening	
Distance Acuity	R _____ L _____
Muscle Balance:	Pass Fail
Corrective Lens:	Yes No
<input type="checkbox"/>	Pass
<input type="checkbox"/>	Referred for evaluation
Signature	Date

Hearing Screening		
25 dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		
<input type="checkbox"/>	Pass	
<input type="checkbox"/>	Referred for evaluation	
Signature	Date	

Scoliosis Screening	
<input type="checkbox"/>	Normal
<input type="checkbox"/>	Referred for evaluation
<input type="checkbox"/>	Under doctor's care for Scoliosis
Signature	Date

Teeth _____
Nose and Throat _____
Skin _____
Hair _____
Thyroid _____
Heart _____
Lungs _____
Orthopedic/Spine _____
Emotional or nervous _____
Nutrition _____
Remarks _____

Date _____

Physician's Signature _____

Printed Name _____