CHILD HEALTH RECORD SCHOOL HEALTH PROGRAM

Date of Visit _____

Child's Name _____ DOB _____ Age (Years/Months) _____
Last First

Temp. _____ BP _____ Pulse _____ R _____ LMP _____ HC _____ WGT _____ HGT _____
BMI_____.___ Weight Status Category (BMI %): ❑less than 5th ❑5th-49th ❑50th-84th ❑85th-94th ❑95th-98th ❑99th and higher
History Summary: _____

_____

ROS: _____
Medication: _____ Immunizations Up To Date: YES NO
Allergies: _____ Immunizations offered: _____

PHYSICAL

Check if normal	Problems
❑ Skin	❑ _____
❑ HEENT	❑ _____
❑ Lymph	❑ _____
❑ Neck	❑ _____
❑ Chest	❑ _____
❑ Breast: Tanner _____	❑ _____
❑ Cardiovascular	❑ _____
❑ Abdomen	❑ _____
❑ Musculoskeletal	❑ _____
❑ Back	❑ _____
❑ Genitalia: Tanner _____	❑ _____
❑ Neurological	❑ _____
❑ Teeth	❑ _____
❑ Other	❑ _____
	_____

SCREENING:
(Check items administered, Circle appropriate # and comment as needed)

❑ Lead _____
❑ Hemoglobin _____
❑ DtaP/TD #1____ #2____ #3____ #4____ #5____
❑ Polio #1____ #2____ #3____ #4____
❑ MMR #1____ #2____
❑ Varicella #1____ #2____
❑ Tdap #1____
❑ Hepatitis B #1____ #2____ #3____
❑ HIB #1____ #2____ #3____ #4____
❑ PCV #1____ #2____ #3____ #4____
❑ PPD _____mm
❑ Hearing: R/_____ decibels L/_____ decibels
❑ Visual Acuity: ❑ with glasses ❑ without glasses:
Near: R/20/____ L/20/____ Both 20/_____
Far: R/20/____ L/20/____ Both 20/_____
❑ Color Perception: *Pass/Fail
❑ Fusion: *Pass/Fail Lens Test: *Pass/Fail
❑ Urinalysis _____
❑ Scoliosis _____
❑ Speech _____
❑ Other _____

Assessment _____
_____
_____
_____

❑ May participate in all sports/physical education/activities.
❑ May participate in limited contact sports only
❑ May participate in non-contact sports only

Referrals _____
_____
_____
_____
_____

Plan _____
_____
_____

❑ Age related Anticipatory Guidance Information provided

Medications needed in school/sports: _____
_____
_____

Provider signature _____Date_____

Attention Parent/Guardian: By signing below, I agree that a copy of this form will be put on file in the school nurse's office. If your child is enrolled in the school health program, a copy will go in their medical record.

Signature _____ Date_____

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