

**NORTH HARRISON COMMUNITY SCHOOL CORPORATION
STUDENT HEALTH HISTORY - TO BE COMPLETED BY
STUDENT'S PHYSICIAN, DENTIST AND EYE CARE PROFESSIONAL**

Parent/Guardian: Once your child's Physician, Dentist, Eye Care Professional complete this form, return to your child's school on or before the first day of school.

Student's Name _____
Last name
First name
Middle name

Birth date _____ Parent's or Guardian's Names _____

ALLERGIES

(List medication/drug allergies and other allergies confirmed by physician)

IMMUNIZATIONS WITH DATES (provide month/day/year)

(Highlighted Immunizations are Required for Newly Enrolled Students in Kindergarten or First Grade)

<i>*Diphtheria, Pertussis, Tetanus</i>	1.	2.	3.	4.	5.
<i>*Polio</i>	1.	2.	3.	4.	
<i>*Measles, Mumps, Rubella</i>	1.	2.			
<i>*Hepatitis B</i>	1.	2.	3.	4.	
HIB	1.	2.	3.	4.	
Varicella/Varivax	1.	2.			

TB Test Date _____ Results _____ If POSITIVE, X-ray results _____

LEAD Test NO ___ YES ___ IF YES, results _____ SICKLE CELL Test NO ___ YES ___ IF YES, results _____

PHYSICIAN – CHECK IF APPLICABLE TO STUDENT AND GIVE DATE OF OCCURRENCE

____ History of tuberculosis-describe treatment
____ History of hospitalization-explain
____ Presently under treatment by physician-explain
____ Taking medication-explain
____ Diabetes-explain/describe treatment if needed at school
____ Skin Conditions-explain
____ Speech/Hearing Difficulties-explain
____ Emotional Disturbances-explain
____ Behavioral Difficulties-explain
____ Asthma-explain/describe treatment if needed at school
____ Seizures/Epilepsy-explain/describe treatment if needed at school
____ Allergic Reactions-explain/describe treatment if needed at school
____ Special Diet-explain/describe if needed at school

____ Chicken pox	____ Scarlet Fever	____ Pneumonia
____ Mumps	____ Polio	____ Bronchitis
____ Measles	____ Diphtheria	____ Herpes
____ Rubella	____ Pertussis	____ Tonsillitis
____ Hepatitis	____ Fifth Disease	____ Impetigo
____ Rheumatic Fever	____ Paralysis	____ Other-explain

PHYSICIAN, DENTIST, EYE CARE PROFESSIONAL: ADDITIONAL MEDICAL-DENTAL-VISION INFORMATION ON THE BACK OF THIS FORM.

STUDENT HEALTH HISTORY TO BE COMPLETED BY STUDENT'S PHYSICIAN, DENTIST, EYE CARE PROFESSIONAL

MEDICAL EXAMINATION

		Normal		Abnormal			Normal		Abnormal	
Temperature	Eyes					Neck				
Pulse	Ears					Extremities				
Respirations	Nose					Back				
Blood Pressure	Throat					Neuro				
Height	Chest					Abdomen				
Weight	Heart					Genitalia				
Nutrition	Head					Urine				

Hearing: Right _____ Left _____

Vision: Right 20/ ____ Left 20/ ____ Referral to eye care professional: YES ____ NO ____

PHYSICIAN RECOMMENDATIONS:

_____ No Restrictions: Normal Exam
 _____ No Restrictions: Abnormal Exam – Explain _____
 _____ Restrictions and suggestions to school: _____

_____ M.D. _____ M.D.
 Date Of Exam Physician Name Printed Physician Signature

EYE - VISION EXAMINATION

Corrected visual acuity: Right 20/ ____ Left 20/ ____

If corrective lenses are prescribed, they are for:
 Constant Wear _____ Desk Work Only _____

EYE CARE PROFESSIONAL COMMENTS - RECOMMENDATIONS: _____

_____ O.D./M.D. _____ O.D./M.D.
 Date Of Exam Name Printed Eye Care Professional Signature

DENTAL EXAMINATION

Primary Teeth
Permanent Teeth
Gums
Orthodontia
Mouth Injuries/Deformities

DENTIST COMMENTS - RECOMMENDATIONS: _____

_____ D.D.S./D.M.D. _____ D.D.S./D.M.D.
 Date Of Exam Dentist Name Printed Dentist Signature

PARENT/GUARDIAN: ONCE YOUR CHILD'S PHYSICIAN, DENTIST, EYE CARE PROFESSIONAL COMPLETE THIS FORM, RETURN TO YOUR CHILD'S SCHOOL ON OR BEFORE THE FIRST DAY OF SCHOOL. 3/10