SCHOOL HEALTH EXAMINATION RECORD

To be completed by Physician **Incarnation Catholic School**

Child's Full Name _____ Male___ Female ___
Last First Middle

Birthdate _____ Date Form Completed _____
Month / Day / Year Month / Day / Year

SCREENING TESTS			
	Right	Left	Referred for further testing
Hearing			
Vision			
If TUBERCULIN test given, please enter the information below:			
	Date	Type	Result
Tuberculin (if tested)			

Please attach Immunization Record

PHYSICAL ASSESSMENT

Check one:

_____Entirely within normal limits

_____ Abnormalities as follows:

_____

_____

_____

Is there any reason why the student cannot carry out a full program of school work?

_____ Yes _____ No

IMMUNIZATIONS *Complete this section only if no immunization record is attached.*					
	Date	Date	Date	Date	Date
DPT or DTaP					
Td					
Polio OPV / IPV					
MMR					
Hepatitis B					
Varicella					
HIB					
Hepatitis A					
Pneumococcal					
Influenza					
Menactra					
Other					

_____ _____
Signature of Examining Physician Physician Name - Please print

Date:_____