

Child Health Record

SCHOOL HEALTH

Child's Name _____
Last First

Date of Birth _____ Date of Visit _____ Age (years/months) _____

Temperature _____ Blood Pressure _____ Pulse _____ Respirations _____
Height _____ Weight _____ Head Circumference _____

History summary: _____

ROS: _____

Medications: _____
ALLERGIES: _____ Immunizations Up To Date YES NO

PHYSICAL	Check if normal	Check if a problem and explain
<input type="checkbox"/> Skin	<input type="checkbox"/>	_____
<input type="checkbox"/> HEENT	<input type="checkbox"/>	_____
<input type="checkbox"/> Lymph	<input type="checkbox"/>	_____
<input type="checkbox"/> Neck	<input type="checkbox"/>	_____
<input type="checkbox"/> Chest/Breast	<input type="checkbox"/>	_____
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	_____
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/> Muskuloskeletal	<input type="checkbox"/>	_____
<input type="checkbox"/> Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/> Neurological	<input type="checkbox"/>	_____
<input type="checkbox"/> Other	<input type="checkbox"/>	_____
<input type="checkbox"/> TANNER _____	<input type="checkbox"/>	_____
<input type="checkbox"/> Speech Screening	<input type="checkbox"/>	_____

Screening:
(Check items administered, comment as needed)

<input type="checkbox"/> Lead _____	Assessment _____
<input type="checkbox"/> Hemoglobin _____	_____
<input type="checkbox"/> DTP booster _____	_____
<input type="checkbox"/> Oral polio booster _____	_____
<input type="checkbox"/> PPD _____	_____
<input type="checkbox"/> Second MMR _____	Referrals _____
<input type="checkbox"/> Hepatitis # _____	_____
<input type="checkbox"/> Hearing Screening: * R/ _____ L/ _____	_____
Visual Acuity : <input type="checkbox"/> with glasses <input type="checkbox"/> without	Plan _____
<input type="checkbox"/> Near: R/ _____ L/ _____	_____
<input type="checkbox"/> Far: R/ _____ L/ _____	_____
<input type="checkbox"/> Color perception: Pass _____ Fail _____	_____
<input type="checkbox"/> Fusion _____	_____
<input type="checkbox"/> Dental Referral _____	_____
<input type="checkbox"/> Urinalysis _____	_____
<input type="checkbox"/> Other _____	_____

Age Related Anticipatory Guidance Information To Home.

Signature _____ Date _____

* P= Pass F= Fail

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 son/daughter is enrolled in the school health program, a copy will go into their medical record.

Parent Signature _____ Date _____