DEPARTMENT OF HEALTH — BOARD OF EDUCATION

SCHOOL HEALTH NEW ADMISSION EXAMINATION

SOCIAL SECURITY # | STUDENT ID #

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT LAST NAME | FIRST NAME | MIDDLE

SEX: ❑ Male ❑ Female

BIRTHDAY: MONTH DAY YEAR

MEDICAID #

1 ❑ Public Elem
2 ❑ Public JHS/S
3 ❑ Public H.S.
4 ❑ Non-Public

SCHOOL NAME:

School District | School Number | ANNEX

GRADE | CLASS | PLACE OF BIRTH

ETHNICITY: 1 ❑ Black 4 ❑ Asian 6 ❑ Hispanic 7 ❑ Am. Ind. 2 ❑ White 8 ❑ Other

❑ PARENT
❑ GUARDIAN

LAST NAME | FIRST NAME

STUDENT ADDRESS | APT/FL | ZIP

TELEPHONE NO. HOME: WORK:

HAS THE STUDENT HAD, OR NOW HAVE ANY OF THE FOLLOWING:

			REASON	DATE	PLACE
❑ ASTHMA	❑ CANCER	❑ HOSPITALIZATIONS			
❑ ALLERGIES	❑ TUBERCULOSIS	❑ SURGERY - WHAT KIND			
_____	❑ ORTHOPEDIC PROBLEMS	❑ SERIOUS ILLNESSES			
❑ CONGENITAL HEART DISEASE	❑ VISION PROBLEMS	❑ SERIOUS ACCIDENTS			
❑ CONVULSIONS	❑ HEARING PROBLEMS	❑ OTHER PROBLEMS OR LIMITATIONS			
❑ DIABETES	❑ SPEECH PROBLEMS				

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

CHILD'S HISTORY:

FAMILY HISTORY:

PHYSICAL EXAMINATION:

HEIGHT _____ (%) WEIGHT _____ (%) BLOOD PRESSURE: _____

GENERAL APPEARANCE (NUTRITIONAL STATUS): _____

NL	AB		NL	AB		NL	AB		NL	AB	
❑	❑	HEENT	❑	❑	LUNGS	❑	❑	EXTREMITIES	❑	❑	PSYCHO/SOCIAL DEVELOPMENTAL
❑	❑	DENTAL STATUS	❑	❑	CARDIOVASCULAR	❑	❑	BACK	❑	❑	LANGUAGE
❑	❑	NECK	❑	❑	ABDOMEN	❑	❑	SKIN	❑	❑	BEHAVIORAL
❑	❑	LYMPH	❑	❑	GENITO URINARY	❑	❑	NEURO	❑	❑	GROSS MOTOR
									❑	❑	FINE MOTOR

DESCRIBE ABNORMALITIES:

SCREENING TESTS:

	DATE	RESULTS
HEMATOCRIT/HEMOGLOBIN		
HGB ELECTROPHORESIS		
OTHER		

	DATE	RESULTS
URINALYSIS		
AUDIO/SWEEP		
THRESHOLD		

VISION	DATE	RESULTS
FAR		
NEAR		
FUSION		
COLOR		

LEAD:

	DATE	RESULTS
FEP		
ZNP		
MICRO LEAD		
VENOUS LEAD		

TB:

MANTOUX (PPD) IMPLANTED _____ DATE
READ _____ DATE

RESULTS: ❑ NEGATIVE _____ MM ❑ POSITIVE _____ MM

CHEST X-RAY DATE _____ RESULTS _____

BCG VACCINE ❑ YES ❑ NO
DATE _____

IMMUNIZATION — DATES

DPT or Dt or Td	/ /	/ /	/ /	/ /	/ /	/ /
POLIO: TOPV (Sabin)	/ /	/ /	/ /	/ /	/ /	
IPV (Salk)	/ /	/ /	/ /	/ /	/ /	
HIB	/ /	/ /				
OTHER _____	/ /	/ /				

MEASLES	/ /	/ /
MUMPS	/ /	/ /
RUBELLA	/ /	/ /
MR	/ /	/ /
MMR	/ /	/ /

TYPES OF PROBLEMS FOUND

❑ NO PROBLEM V655

	DOH ONLY	STATUS/PLAN	DOH FOLLOW-UP
1.		1.	1.
2.		2.	2.
3.		3.	3.

RECOMMENDATIONS — Please specify limitations and or special alerts (i.e. allergies, medications, precautions)

❑ FULL PHYSICAL ACTIVITY ❑ RESTRICTIONS *(Specify)*

PHYSICIAN NAME: *(Print)* _____