

**St. Gabriel Consolidated School
Student Health History**

TO BE COMPLETED BY PHYSICIAN

Child's Full Name _____ Date of Birth _____

Date of Last Physical _____ Height _____ Weight _____

Vital Signs: BP: _____ Temperature _____ Pulse _____ Respiration _____

Skin (color, condition, eruptions?) _____

Head (size, shape, symmetry) _____

Nose _____ Throat _____ Neck _____

Chest _____ Heart _____ Lungs _____

Abdomen _____

LABORATORY RESULTS

Does this child have any physical, developmental or behavioral problems that the school needs to be aware of _____

Do you suggest any special programs, placement or attention that the school can provide?

This child is essentially within normal limits Yes No

If no, explain: _____

ACTIVITIES & LIMITATIONS

Is this child capable of carrying:

A full program of school work including physical education classes? Yes No

Extracurricular activities including athletics? Yes No

Would you recommend any restrictions? Yes No

If yes, explain: _____

OVER

