

**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 _____

PHYSICAL EXAMINATION

Skin (color, condition, eruptions?) _____

Head and Neck _____ Nose _____ Throat _____

Abdomen _____ Chest _____ Heart _____ Lungs _____

Surgical History:

Medical History:

Perinatal History:

Allergies (please list treatment):

Medications:

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

SCREENING TESTS:

<i>Vision</i>	Date	<i>Hearing</i>	Date
Distance Acuity	Near: Right _____ Left _____ Far: Right _____ Left _____	Pure Tone Testing:	Right _____ Left _____
Muscle Balance	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Does child wear hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Was child tested with hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does child wear glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was a referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was child tested with glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was a referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>Speech Assessment</i>		Date	
<input type="checkbox"/> Child has no discernible speech problem <input type="checkbox"/> Child has a possible problem with:		<input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language	
Was a referral made?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

IMMUNIZATION RECORD:

DPT/DtaP/DT/Td	_____
Polio	_____
MMR	_____
Hepatitis B	_____
Varivax Vaccine	_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

Physician's Name Printed: _____

Office Address _____

Office Phone # _____