

To the Health Care Provider: Please complete and sign.

_____ has had a complete history and physical exam on _____
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record					
Note: * Mandated Screening/Test under Connecticut State Law			Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.					
* Height:		BMI:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
* Weight:		* Postural:	DTP	*	*	*	*	
* Blood Pressure:		<input type="checkbox"/> Normal	DTP/Hib					
Pulse:		<input type="checkbox"/> Abnormal	DTaP					
* HCT/HGB:		Min. _____	DT/Td					
Urinalysis:		Slight _____	OPV	*	*	*		
* Gross dental:		Mod. _____	IPV	*	*	*		
Lead (Date/Result)		Marked _____	MMR					
		<input type="checkbox"/> Referral	Measles	*	*		Booster for entry into K and 7th grade	
TB and Other Test Results (Sickle Cell, etc.)			Mumps	*				
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			Rubella	*				
Test	Date	Results	HIB	*			Students under age 5	
			Hep B	*	*	*	Req. for entry into K and 7th grade.	
* Vision/ Type of Screening			Varicella	*			Students born 1/1/97 or later. Required for 7th grade entry.	
* Auditory/ Type of Screening			PCV				Pneumococcal conjugate vaccine	
With glasses	R 20/ L 20/	Pass/Fail R	Other Vaccines (Specify)					
Without glasses	R 20/ L 20/	L						
* Chronic Disease Assessment:			Disease Hx					
Yes	No	Date of onset	of above _____ (Specify) _____ (Date) _____ (Confirmed by)					
<input type="checkbox"/>	<input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____	Exemption					
<input type="checkbox"/>	<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified	_____	Religious _____ Medical: Permanent _____ Temporary _____ Date _____					
<input type="checkbox"/>	<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II	_____	Recertify Date _____ Recertify Date _____ Recertify Date _____					
<input type="checkbox"/>	<input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex	_____						
<input type="checkbox"/>	<input type="checkbox"/> Seizure Disorder	_____						
<input type="checkbox"/>	<input type="checkbox"/> Other: Please specify _____	_____						

This student has the following problems which may adversely affect his or her educational experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaptation.
(Specify reason and restriction.) _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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