WA-NEE COMMUNITY SCHOOLS

SCHOOL: _____ GRADE: _____

HEALTH INFORMATION **TO BE FILLED OUT BY PARENT OR GUARDIAN**

NAME: _____ BIRTHDATE: _____

PARENT OR GUARDIAN: _____ PHONE #: _____

ADDRESS: _____ CITY/ZIP: _____

If student has any of the following conditions, explain briefly:

Hearing Loss _____ Seizure Disorder _____
Speech Defect _____ Allergies _____
Asthma _____ Diabetes _____
Other _____
Takes medication regularly _____
If so, name these: _____
_____

Have there been any serious illnesses, accidents or surgery that has caused any impairment?
Yes___ No ___ If yes, what _____

Signature of parent or guardian _____

IMMUNIZATIONS

	#1 m/d/y	#2 m/d/y	#3 m/d/y	#4 m/d/y	#5 m/d/y
DTaP/DPT					
Td/DT					
Tdap					
IPV					
Hib					
Varicella					
MMR					
Meningococcal					
Pneumococcal (PCV7)					

#1 m/d/y	#2 m/d/y	#3 m/d/y
Hepatitis B		
Hepatitis A		

Chickenpox disease: YES: (date)_____ No: _____
Verified by: _____(Physician Signature)

DOCTOR'S EXAMINATION

CODE: No defect = 0
If defect = Note condition

NAME: _____

EYES: _____

Visual Acuity R ___/___ L___/___

Wears Glasses: _____

EARS: _____

Hearing (gross) _____

Referred to eye specialist: _____

Height:	**Urinalysis:**
Weight:	**Hemoglobin:**
Blood Pressure:	**OR Hematocrit:**
Nose:	**Abdomen:**
Throat:	**Hernia:**
Heart:	**Reflexes:**
Lungs:	**Genitalia:**
Skin:	**Orthopedic:**
Glands: Lymph	

Physically fit to participate in physical education program? YES ___ NO ___
Competitive Sports YES ___ NO ___

Restrictions? _____
Please explain:

_____

_____

Date of Examination: _____
Office Phone: _____
Physician's Signature: _____

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DENTAL EXAMINATION

CODE: No defect = 0
If Defect = note condition

Teeth _____ Infection _____

Para-Oral Structure _____ Abnormalities _____

Is further treatment necessary: Immediate care: ___ Routine care: YES ___ No__

Have arrangements been made for further treatment: YES ___ NO ___

Comments:

_____

_____

Date of Examination: _____
Office Phone: _____
Dentist's Signature: _____