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 _____

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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					
OPV					
IPV					
Hib					
Varicella					
M.M.R.					
Meningococcal					

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

Chickenpox disease _____ Yes _____No
If yes, give date _____

TB SKIN TEST: Date _____ Pos. _____ Neg._____
(optional)

DOCTOR'S EXAMINATION

CODE: No defect = 0 NAME:_____
If defect = Note condition

EYES: _____ EARS:_____
Visual Acuity R__/__ L__/__ Hearing (gross)_____
Wears Glass_____
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:

_____ _____ _____