

CERTIFICATE OF CHILD HEALTH EXAMINATION

(Information on this form may be shared with appropriate personnel for health and educational purposes)

Please PRINT or TYPE

Pupil's Name Birthdate Sex: Male Female
Address Telephone #:
Parent/Guardian Name(s)

MEDICAL HISTORY (TO BE COMPLETED BY PARENT)

- Chicken Pox Year Congenital Defects:
Scarlet Fever Year Diabetes:
T.B. / T.B. Contact Year Epilepsy:
Heart Disease:
Frequent Ear Infections:
Injuries / Accidents: Year Results:
Permanent Disability: Year Type:
Surgery: (operations) Year Type:
Allergies: (list)
Taking Medication(s): (list medications and reason for use):

IMMUNIZATIONS: Please provide the month, day, and year for every dose administered

Table with 10 columns for immunization types (DPT, Whooping Cough, DT, Tetanus, Polio, MMR, HIB, Hepatitis B, Tuberculin Test, Chest X-Ray, Other, Varicella) and 10 columns for dates.

(To be completed by Physician) PHYSICAL EXAMINATION

Evaluation: Required Strongly Recommended

Table for physical examination with columns for Normal, Abnormal, Follow-Up Comment for Height, Weight, Respiratory, Cardiovascular, Gastrointestinal, Muscular/Skeletal, Genito/Urinary, Vision Screen, Scoliosis Screen, Hemoglobin, Hematocrit, Urinalysis, Lead Screening, Sickle Cell.

Special Diet Needs: Restrictions / Needs:

Special Equipment Needs:

Medical Health Care Needs: (I.E. treatments needed to be performed while student is at school such as catheterizations or tube feedings) include type of treatment and frequency it is to be performed at school:

Physical Activity: Based on your examination do you approve this child's participation in:

Physical Education: Yes No Interscholastic Sports: Yes No

Physician Signature: Telephone:

Address: Date of Exam:

DENTAL EXAMINATION RECORD

(Information on this form may be shared with appropriate personnel for health and educational purposes)

Please **PRINT** or **TYPE**

Pupil's Name _____ Birthdate _____ Sex: Male Female

Address _____ Telephone #: _____

1. Does your child have any medical problem that may complicate dental treatment? (i.e. allergies, diabetes, respiratory difficulty, history of rheumatic fever, etc.?) Yes No

Explain: _____

THIS PORTION TO BE COMPLETED BY DENTIST

Date exam performed: _____

Current Dental Status of Patient:

- URGENT: abscess formation, nerve exposure, advanced disease state including handicapped individuals.
- ROUTINE DENTAL CARE NEEDED: alloys, composites, stainless steel crowns, etc.
- PREVENTATIVE DENTISTRY ONLY NEEDED: prophylaxis, fluoride treatment, sealants
- NO TREATMENT REQUIRED
- OTHER

Pathology Present:

Hard Tissue: Yes No Describe: _____

Soft Tissue: Yes No Describe: _____

Malocclusion: Yes No Type: _____

Orthodontic Referral Recommended: Yes No

Dentist Signature _____

Address _____

Phone _____

