INDIANA HORIZON ACADEMY
STUDENT HEALTH RECORD & EXAMINATION

NAME _____SEX _____ DATE OF BIRTH_____

PARENTS_____ ADDRESS _____

_____

SCHOOL _____ GRADE _____ PHONE _____

TO BE ANSWERED BY PARENT: Are there any significant factors in your child's health history that could affect his/her mental or physical learning disability? Are there any allergies or other problems present of which the school health nurse should be aware? Is your child taking any medicine regularly?

Please detail. _____

_____

IMMUNIZATION RECORDS

Dose	DTAP/TD	IPV (Polio)	Hib	MMR	HEP A	HEP B	Varicella Varivax	Pneumococcal PCV(Prevnar)
#1								
#2								
#3								
#4								
#5								

If the child has chickenpox, please provide a written documentation of history of the disease, including month And year of the disease

PHYSICAL EXAMNIATION

Height _____ Weight_____ Urinalysis _____ Throat _____ Chest _____

Abdomen _____ Nose _____

Please record any abnormal physical or developmental findings _____

_____

Should physical activities be restricted? _____

Comments and recommendations _____

_____

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Please provide us a written prescription for over the counter medicines we can administer at the school.

Specify the name of the medicine, dosage, frequency and why it should be given. This note will be renewed every two years.

PART II - STUDENT MEDICAL HISTORY (to be completed by the doctor)

Name of Student _____

Parent's Name _____ Phone _____

(Circle One)

Yes – No 1. Has had injuries requiring medical attention.

Yes – No 2. Has had illness lasting more than a week.

Yes - No 3. Is under physician's care now.

Yes - No 4. Takes medication now.

Yes – No 5. Wears glasses. Contact lenses Yes - No

Yes – No 6. Has had surgical operation.

Yes - No 7. Has been in the hospital (except for tonsillectomy)

Yes - No 8. Do you know of any reason why the individual should not participate in all sports?

Please explain any "Yes" answers to above questions._____

Yes - No 9. Has had complete poliomyelitis immunization.

Yes - No 10. Has had a dental check-up within the past 6 months.

11. Most recent tetanus toxoid immunization date. _____

STATEMENT OF PHYSICIAN

This child has been adequately immunized _____.

This child requires further immunizations which will be completed by me within 30 days _____ within 60 days _____. This child requires further immunizations which should be completed by health department_____.

Signed _____ Date _____