ADMISSIONS

CONFIDENTIAL

HEALTH EXAMINATION

To be completed by Physician, Physician Assistant or Nurse Practitioner

Student's Name: ______________________ Date of Birth: ______________
Day / Month / Year

Please check any history of the following:

	Allergy (food, drug, environmental, tape)		Asthma		Heart condition/Hypertension
	Behavioural problems		Head/Neck injury		Diabetes
	Hearing/Vision problems		Seizures/Epilepsy		Stomach/Digestive problems
	Kidney/Bladder disorders		Blood disorders		Bone/Joint disorders
	Concussion/Unconsciousness		Sport related injuries		Speech diff culties
	Chest pain / dizziness while exercising		Heat or cold related injuries		Headaches
	Skin problems		Other		

Please explain any areas checked above: ______________________

Signif cant past illness, injuries or operations: ______________________

Medication or special diets: ______________________

Required Immunizations *(please provide copy of original immunization document)*

- 5 DPT's or DT's (Diptheria, Tetanus, Pertussis) – one booster between ages of 4-6 years
- 4 OPV's or IVP's (Polio) – one booster between ages of 4-6 years
- 2 MMR's (Measles, Mumps and Rubella) – one after 12 months and a second booster between 4-6 years
- Tuberculosis test with negative results (up to 12 months) prior to starting school and every other year thereafter
- Chest x-ray if Tuberculosis test positive
- HIB series (Haemophilus Inf uenza Type B) – under 5 year of age
- Tetanus booster every 10 years
- Hepatitis A & B, Pneumococcal, Meningococcal and Chicken Pox vaccines strongly recommended

Physical Examination:

Height: ________ Weight: ________ BP: ________ Pulse Rate: ________ Urinalysis ________

Vision (without glasses): R ______ / ______ L ______ / ______ Hearing: R ______ L ______

Vision (with glasses): R ______ / ______ L ______ / ______ Audiogram/Tympanogram ______

	Normal	Abnormal	Not Examined	Comments
Eyes				
Ears, Nose, Throat				
Mouth & Teeth				
Neck (soft tissue)				
Cardiovascular				
Abdomen				
Genitalia-hernia				
Sexual maturity				
Skin & Lymphatics				
Neck & Spine				
Shoulders				
Arms & Hands				
Hips & Thighs				
Knees, Feet & Ankles				
Neurological				

______ No history or physical f ndings on this exam would prohibit this student from participating in team sports.

Recommendations & comments: ______________________

Immunizations given at this visit: ______________________

Physician's name *(print)* ______________ Signature ______________ Date ______________

Address: ______________________