



Student Health History and Physical Examination

Student's Name: _____ DOB: _____ • M • F

Address: _____ SCHOOL _____ GRADE _____

Hospitalizations/Surgery: _____

Medications: _____

Ht: _____ Wt: _____ BMI: _____ BP: _____ / _____

Vision: R ___ / ___ L ___ / ___ Hearing: _____ Scoliosis: • Yes • No

Allergies: Foods _____ Meds _____
Other _____ Anaphylaxis _____ EPI pen Yes No

Asthma: Active Inactive Asthma Action Card® Diabetes: Type 1 Type 2 Pump

	WNL	ABNORMAL: comments
Skin		
Skeletal		
HEENT		
Neck		
Lung		
Heart		
Abd/ GI		
GU		
Neuro		

Impression: _____

Full Physical Activity

Restricted Physical Activity

Vaccine	1st	2nd	3rd	4th	5th
DTaP					
Tdap					
OPV/IPV					
MMR					
Hib					
HepB					
HepA					
Varicella					
Meningococcal					
Pneumococcal					
HPV					

PPD:

Date administered: _____

Results: _____ mm

CXR: _____ Prophylaxis: _____

Varicella Disease:

Date: _____

Physician Signature _____ Date _____

Address: _____