Bet Shraga Hebrew Academy of the Capital District

Health History for ____ Grade ______ page 1

All information contained herein is to be completed by the parents or guardian. All information contained herein is considered confidential and will be filed in the Health Office. It will be used only for the purpose of evaluating your child's health status.

1. Has your child had any of the following:

Chicken Pox	Y	N	Diabetes	Y	N
Scarlet Fever	Y	N	Kidney/Bladder Disease	Y	N
Tuberculosis	Y	N	Heart Disease/Heart Murmur	Y	N
Tuberculosis Contact	Y	N	Epilepsy/Seizures	Y	N
Pneumonia	Y	N	Anemia/Bleeding Disorders	Y	N
Hepatitis	Y	N	Cancer	Y	N
Mononucleosis	Y	N	Sickle Cell Anemia	Y	N
Rheumatic Fever	Y	N	Elevated Blood Pressure	Y	N
Arthritis	Y	N	Head Injury/Concussion	Y	N
Skin Disorders	Y	N	Frequent Ear infections	Y	N
Speech Problem	Y	N	Asthma	Y	N
Problem Headaches	Y	N	Ulcers/Abdominal Pain/Reflux	Y	N
Constipation/Diarrhea	Y	N	Serious Injury	Y	N
Hospitalization/Surgery	Y	N	Other Medical Illness	Y	N

Please explain any "yes" answers:

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2. Does your child have any eye or vision problems? Does he/she wear glasses or contacts? If so, please explain.

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3. Does your child have any hearing problems or require hearing aids? If so, please explain

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4. Does your child take any medications including inhalers? If so, please provide names and dosages of medications.

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5. Does your child have any allergies to food, latex, medications or stinging insects? If so, please explain

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6. Does your child have any physical limitations? If so, please explain.

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian: ________________________________ Date ____________

Physical Exam

Grade __________

Name of Student:______________________________ D.O.B.: ________ Sex: ______ Height: _______
Weight: ______ BP: _____ P: _____ R: _____ Audiometric Testing (optional) R: ______ L: _______
Vision R: 20/_____ L: 20/_____ Both: 20/_______ Corrected: Y N

	Normal	Abnormal Findings/Comments
General/Nutrition		
Skin/Hair/Scalp		
Eyes		
Nose		
Ears		
Mouth/Pharynx/Tonsils		
Lymph Nodes		
Thyroid		
Spine/Scoliosis		
Chest		
Lungs		
Heart		
Abdomen		
Femoral Pulses		
Genitalia		
Hernia		
Musculoskeletal/Neurologic*		
Physical Stigmata of Marfan's Syndrome		

*If indicated by history or exam, please provide details of more targeted musculoskeletal exam here.

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Please complete in full if the student is new to the school. For returning students, simply indicate interim immunizations

	Date Each Dose Was Given				
	1st	2nd	3rd	4th	5th
Polio Type:					
Measles					
Mumps					
Rubella					
MMR					
DPT (Full doses only)					
DT (Full doses only)					
Tetanus					
HIB					
Hep B. Series					
Varicella					
Other					

Signature of Physician: ________________________________ Phone # of Physician: ______________

Physician's printed name or stamp: _______________________________ Date of Exam: _____________