NAALEH HIGH SCHOOL FOR GIRLS HEALTH EXAMINATION FORM

(Students participating in sports teams must also complete the Athletic Pre-Participation Physical Evaluation Form)

Last Name______________________________ First Name____________________________ MI _____________

Address _______________________________________ City State Zip Code ______________________________

◻ Female ◻ Male Date of Birth (Month/Day/Year)____/_____/20____

PHYSICAL EXAM: Height _________ Weight _________ BMI ________ Blood Pressure _____/____

Date of last exam: _____/______/20____

GENERAL APPEARANCE

NI	Abnl		NI	Abnl		NI	Abnl	
◻	◻	HEENT	◻	◻	Back/Spine	◻	◻	Genitourinary
◻	◻	Dental	◻	◻	Neck	◻	◻	Cardiovascular
◻	◻	Abdomen	◻	◻	Skin	◻	◻	Neurological
◻	◻	Lymph Nodes	◻	◻	Language	◻	◻	Psychosocial Development
◻	◻	Extremities	◻	◻	Lungs	◻	◻	Behavioral

DESCRIBE ABNORMALITIES:____

DOES THE CHILD HAVE A PAST OR PRESENT MEDICAL HISTORY OF THE FOLLOWING:

◻ Asthma (check severity & attach MAF/Asthma Action Plan) ◻ Intermittent ◻ Mild Persistent ◻ Moderate Persistent ◻ Severe Persistent If persistent, check all current medication(s): ◻ Inhaled corticosteroid ◻ Other controller ◻ Quick relief med ◻ Oral Steroid ◻ None

◻ Attention Deficit Hyperactivity Disorder
◻ Anxiety
◻ Bleeding disorders
◻ Chronic or recurrent otitis media
◻ Congenital or acquired heart disorder
◻ Developmental/learning problem
◻ *Diabetes (attach MAF)*
◻ Eating disorders
◻ Headaches/Migraines
◻ Orthopedic injury/disability
◻ Previous Surgery
◻ Seizure
◻ Speech, hearing or visual impairment
◻ Stomach/Intestinal disorder
◻ Thyroid Disease
◻ Tuberculosis, latent infection or disease

◻ Other (Specify) ____

Explain all checked items above or on addendum: _____________________________________

Dietary Restrictions (please list): _________________________ ◻ Lactose Intolerant

Medications (attach MAF if in-school medication is needed) ◻ None ◻ Yes (please list):

____

SCREENING TESTS: **Hearing** ◻ Pure tone audiometry ◻ OAE ◻ Normal ◻ Abnormal Date: ___/___/___

Vision __/__/__ ◻ W/ Glasses Acuity Right __/___ Left ___/___Strabismus ◻ No ◻ Yes Date: ___/___/___

Scoliosis ◻ Normal ◻ Abnormal Date: ___/ ___/____ Tuberculosis_PPD/Mantoux placed Date:___/___/___

PPD/Mantoux read Date:____/____/_____ ◻ NI ◻ Abnl ◻ Not Indicated

RECOMMENDATIONS

□ Full physical activity □ Full diet □ Restrictions (specify) ____

Follow-up Needed □ No □ Yes , for ____

OVERALL ASSESSMENT:

□ **Well Child** □ **Diagnoses/Problems (explain):** ____

Health Care Provider (print) ____

Facility Name ____

Address City State Zip ____

Telephone ______________________________ **Fax**____

Health Care Provider Signature____ **Date** ____/____/20_____

PLEASE ATTACH IMMUNIZATION RECORDS

RETURN FORM TO: *nurse@naalehhighschool.org*