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*