NORTH HARRISON COMMUNITY SCHOOL CORPORATION
STUDENT HEALTH HISTORY - TO BE COMPLETED BY
STUDENT'S PHYSICIAN, DENTIST AND EYE CARE PROFESSIONAL

Parent/Guardian: Once your child's Physician, Dentist, Eye Care Professional complete this form, return to your child's school on or before the first day of school.

Student's Name _____
Last name First name Middle name

Birth date _____ Parent's or Guardian's Names _____

ALLERGIES

(List medication/drug allergies and other allergies confirmed by physician)

_____

_____

IMMUNIZATIONS WITH DATES (provide month/day/year)

(Highlighted Immunizations are Required for Newly Enrolled Students in Kindergarten or First Grade)

****Diphtheria, Pertussis, Tetanus***	**1.**	**2.**	**3.**	**4.**	**5.**
****Polio***	**1.**	**2.**	**3.**	**4.**	
****Measles, Mumps, Rubella***	**1.**	**2.**			
****Hepatitis B***	**1.**	**2.**	**3.**	**4.**	
HIB	**1.**	**2.**	**3.**	**4.**	
****Varicella/Varivax***	**1.**	**2.**			
Hepatitis A	**1.**	**2.**			

PHYSICIAN – CHECK IF APPLICABLE TO STUDENT AND GIVE DATE OF OCCURRENCE

___History of tuberculosis-describe treatment
___History of hospitalization-explain
___Presently under treatment by physician-explain
___Taking medication-explain
___Diabetes-explain/describe treatment if needed at school
___Skin Conditions-explain
___Speech/Hearing Difficulties-explain
___Emotional Disturbances-explain
___Behavioral Difficulties-explain
___Asthma-explain/describe treatment if needed at school
___Seizures/Epilepsy-explain/describe treatment if needed at school
___Allergic Reactions-explain/describe treatment if needed at school
___Special Diet-explain/describe if needed at school

___Chicken pox	___Scarlet Fever	___Pneumonia
___Mumps	___Polio	___Bronchitis
___Measles	___Diphtheria	___Herpes
___Rubella	___Pertussis	___Tonsillitis
___Hepatitis	___Fifth Disease	___Impetigo
___Rheumatic Fever	___Paralysis	___Other-explain

PHYSICIAN, DENTIST, EYE CARE PROFESSIONAL: ADDITIONAL MEDICAL-DENTAL-VISION INFORMATION ON THE BACK OF THIS FORM.

04/13

Name of Student_____

HEALTH HISTORY TO BE COMPLETED BY STUDENT'S PHYSICIAN, DENTIST, EYE CARE PROFESSIONAL

MEDICAL EXAMINATION

		Normal		Abnormal			Normal		Abnormal	
Temperature	**Eyes**					**Neck**				
Pulse	**Ears**					**Extremities**				
Respirations	**Nose**					**Back**				
Blood Pressure	**Throat**					**Neuro**				
Height	**Chest**					**Abdomen**				
Weight	**Heart**					**Genitalia**				
Nutrition	**Head**					**Urine**				

Hearing: Right _____ Left _____

Vision: Right 20/ ___ Left 20/___ Referral to eye care professional: YES ___ NO ___

PHYSICIAN RECOMMENDATIONS:

____ No Restrictions: Normal Exam
____ No Restrictions: Abnormal Exam – Explain _____
____ Restrictions and suggestions to school: _____
_____

_____ _____M.D. _____M.D.
Date Of Exam Physician Name Printed Physician Signature

EYE - VISION EXAMINATION

Corrected visual acuity: Right 20/____ Left 20/____

If corrective lenses are prescribed, they are for: Constant Wear _____ or
Desk Work Only_____

EYE CARE PROFESSIONAL COMMENTS - RECOMMENDATIONS: _____

_____

_____ _____O.D./M.D. _____O.D./M.D.
Date Of Exam Name Printed Eye Care Professional Signature

DENTAL EXAMINATION

Primary Teeth
Permanent Teeth
Gums
Orthodontia
Mouth Injuries/Deformities

DENTIST COMMENTS - RECOMMENDATIONS: _____

_____

_____ _____.D.D.S./D.M.D. _____D.D.S./D.M.D.
Date Of Exam Dentist Name Printed Dentist Signature

PARENT/GUARDIAN: ONCE YOUR CHILD'S PHYSICIAN, DENTIST, EYE CARE PROFESSIONAL COMPLETE THIS FORM, RETURN TO YOUR CHILD'S SCHOOL ON OR BEFORE THE FIRST DAY OF SCHOOL. 04/13