

STUDENT HEALTH EXAM

*Exam to be done by a licensed doctor or nurse practitioner
within 3 months before entering school.*



Student's Name: _____ Date of Birth: _____ Sex: F / M
Last First Middle Month/Day/Year (circle)

A. HEALTH HISTORY (including serious injury, illness or surgery): _____

B. CURRENT HEALTH CONCERNS

Yes No

- Allergies *If yes, please complete Allergy Care Plan*
 History of anaphylaxis to: _____ Epi-Pen®: Yes No
- Asthma *If yes, please complete Asthma Care Plan*
- Diabetes *If yes, please complete Diabetes Care Plan*
- Seizure disorder *If yes, please complete Epilepsy/Seizure Care Plan*
- Other *Please specify:* _____

C. CURRENT MEDICATIONS (prescription and non-prescription)

Yes No

- If yes, please complete Authorization for Medication to be Given at School*

D. PHYSICAL EXAM Date of Examination: ____/____/____ Age: ____ years & ____ months
(dd/mm/yyyy)

Height: _____ Weight: _____ BMI: _____ BP: _____ mmHg Pulse: _____/min

	Normal	Abnormal	Comments
Head, neck	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes (pupils) ENT	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth, gums	<input type="checkbox"/>	<input type="checkbox"/>	
Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Spine (scoliosis), back	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulders, upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Hips, lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/mental health	<input type="checkbox"/>	<input type="checkbox"/>	
Nutritional status	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental status	<input type="checkbox"/>	<input type="checkbox"/>	

Vision Screening <i>(required)</i>			Hearing Screening <i>(recommended)</i>				
Uncorrected	R: 20/____	L: 20/____		500	1000	2000	4000
Corrected	R: 20/____	L: 20/____	Right:				
by wearing	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact lenses	Left:				

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E. TUBERCULOSIS SCREENING

Lincoln School requires students to provide evidence of being free from tuberculosis. Please perform and record the results of the appropriate TB screening test(s) for this child. Contact the school nurse if you have questions regarding which test is required.

BCG vaccine <i>Not required</i> <ul style="list-style-type: none"> <i>Date must be documented.</i> 	Date (mm/dd/yyyy): ____/____/____
TB Skin Test (Mantoux, PPD 5 TU) REQUIRED if: <ul style="list-style-type: none"> <i>BCG more than 5 years ago, and/or</i> <i>no history of TB disease or "positive" TB Skin Test</i> 	Date given (mm/dd/yyyy): ____/____/____ Date read (mm/dd/yyyy): ____/____/____ Result (in mm induration): _____ mm
Chest X-ray <i>Required ONLY</i> if: <ul style="list-style-type: none"> <i>new or prior "positive" TB Skin Test, or</i> <i>history of TB disease, or</i> <i>indicated by current health history or exam</i> 	Date (mm/dd/yyyy): ____/____/____ Result:
Medical Examination <i>Required ONLY</i> if: <ul style="list-style-type: none"> <i>new "positive" TB Skin Test, or</i> <i>abnormal chest x-ray, or</i> <i>BCG less than 5 years ago</i> 	Date (mm/dd/yyyy): ____/____/____ Result:

F. IMMUNIZATIONS

To attend Lincoln School a student must have immunity against diphtheria, tetanus, polio, measles, mumps and rubella. Additional childhood and travel immunizations are recommended. *Please attach a copy of all immunization records.* The Health Office will document vaccines on an Immunization Status Certificate.

G. RECOMMENDATIONS

- Yes No
- Approved for participation in age appropriate **physical education and after school activities**
- Approved for participation in age appropriate **Explore Nepal activities** (*grades 5-12*)
- Approved for participation in age appropriate **competitive sports**, with *Sports Eligibility Health History attached (grades 5-12 if participating in a competitive sport)*

If no, describe restrictions or precautions _____

Name of examiner: _____ Signature: _____

Address: _____ Designation: MD / MBBS / NP (*circle*)

Email: _____ Date: _____ (*mm/dd/yyyy*)

Please attach additional information as needed for the health and safety of the student.