



Saint Saviour High School

588 Sixth Street • Brooklyn • New York 11215

Telephone: (718) 768-4406

educating the young women of Brooklyn since 1917

SCHOOL HEALTH EXAMINATION GRADES 10, 11 & 12

Medical Examination must be dated AFTER June 1st. Original forms and signatures required.

TO BE COMPLETED BY PARENT OR GUARDIAN					GRADE	BIRTHDAY MONTH DAY YEAR	STUDENT SOCIAL SECURITY NUMBER
STUDENT LAST NAME	FIRST NAME	MIDDLE				/ /	
STUDENT ADDRESS					Place of Birth		
APT CITY STATE ZIP					<input type="checkbox"/> NYC <input type="checkbox"/> NYS <input type="checkbox"/> OTHER _____		
ETHNICITY:							
<input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> SOUTH PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER _____							
<input type="checkbox"/> PARENT LAST NAME <input type="checkbox"/> GUARDIAN FIRST NAME <input type="checkbox"/> FOSTER PARENT		TELEPHONE		HOME: () - WORK: () -			
HAS THE STUDENT HAD, OR NOW HAVE ANY OF THE FOLLOWING:							
1 <input type="checkbox"/> ASTHMA	6 <input type="checkbox"/> CANCER	12 <input type="checkbox"/> HOSPITALIZATIONS _____					
2 <input type="checkbox"/> ALLERGIES	7 <input type="checkbox"/> TUBERCULOSIS	13 <input type="checkbox"/> SURGERY - WHAT KIND _____					
_____	8 <input type="checkbox"/> ORTHOPEDIC PROBLEMS	14 <input type="checkbox"/> SERIOUS ILLNESS _____					
3 <input type="checkbox"/> CONGENITAL HEART DISEASE	9 <input type="checkbox"/> VISION PROBLEMS	15 <input type="checkbox"/> SERIOUS ACCIDENTS _____					
4 <input type="checkbox"/> CONVULSIONS	10 <input type="checkbox"/> HEARING PROBLEMS	17 <input type="checkbox"/> OTHER PROBLEMS OR LIMITATIONS _____					
5 <input type="checkbox"/> DIABETES	11 <input type="checkbox"/> SPEECH PROBLEMS						
ASTHMA							
In the past 12 months has your daughter had any of the following symptoms?							
<input type="checkbox"/> Wheezing or whistling sound in the chest?							
<input type="checkbox"/> Coughing with exercise?							
<input type="checkbox"/> Dry coughing at night when she does not have a cold?							
<input type="checkbox"/> None							
In the past 12 months has your daughter taken any medicines for these symptoms?							
<input type="checkbox"/> Yes <input type="checkbox"/> No							
In the past 12 months has your daughter made an urgent visit to a doctor or hospital emergency room because of asthma or other breathing problems?							
<input type="checkbox"/> Yes <input type="checkbox"/> No							
To insure proper care of your daughter in case of illness, please complete the information below: (Please Print)							
Name of the person to call in an emergency _____							
Telephone Number _____				Relationship to student _____			
Physician's Name _____ and Telephone _____							
In case of extreme emergency, it is understood that the student will be taken to the nearest hospital, accompanied by a member of the school staff.							
DATE _____				SIGNATURE OF PARENT/GUARDIAN _____			
PLEASE PRINT LAST NAME _____				FIRST NAME _____			

CONTINUED ON REVERSE

TO BE COMPLETED BY STUDENTS HEALTH CARE PROVIDER

STUDENTS HISTORY:

FAMILY HISTORY:

PHYSICAL EXAMINATION: Height _____ in.(%ile) Weight _____ lb.(%ile) Blood Pressure _____ / _____

General Appearance (Nutritional Status)

NOR ABN	NOR ABN	NOR ABN	NOR ABN
___ 1 ___ HEENT	___ 5 ___ LUNGS	___ 9 ___ EXTREMITIES	___ 13 ___ PSYCHO/SOCIAL DEVELOP.
___ 2 ___ DENTAL STATUS	___ 6 ___ CARDIOVASCULAR	___ 10 ___ BACK	___ 14 ___ LANGUAGE
___ 3 ___ NECK	___ 7 ___ ABDOMEN	___ 11 ___ SKIN	___ 15 ___ BEHAVIORAL
___ 4 ___ LYMPH	___ 8 ___ GENITO URINARY	___ 12 ___ NEURO	___ 16 ___ GROSS MOTOR
			___ 17 ___ FINE MOTOR

DESCRIBE ABNORMALITIES:

SCREENING TESTS:	DATE	RESULTS	DATE	RESULTS	VISION
HEMATOCRIT/HEMOGLOBIN	___ / ___ / ___	ž/ž.ž	URINALYSIS	_____	RIGHT / /
HGB ELECTROPHORESIS	___ / ___ / ___	_____	AUDIO/SWEEP	_____	LEFT / /
OTHER	___ / ___ / ___	_____	THRESHOLD	_____	BOTH / /
TB: MANTOUX	DATE	RESULTS	CHEST X-RAY	DATE	RESULTS
(PPD) IMPLANTED	_____	___ NEGATIVE ___ MM	___ / ___ / ___	___ / ___ / ___	_____
READ	_____	___ POSITIVE ___ MM	BCG	___ / ___ / ___	___ YES ___ NO
					DATE / /
					FUSION P F / /

LEAD: DATE DONE RESULTS DATE DONE RESULTS

RISK ASSESSMENT ___ / ___ / ___ LEAD SCREENING ___ / ___ / ___

IMMUNIZATIONS ON FILE AT SCHOOL. ONLY LIST ADDITIONAL BOOSTERS BELOW

MCV4	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Other	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Other	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Other	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Other	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Other	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___

TYPES OF PROBLEMS FOUND

___ WELL CHILD V202	ICD CODE						
1. _____	<table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>						
2. _____	<table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>						
3. _____	<table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>						

RECOMMENDATIONS

Please specify limitations and or special alerts
(i.e. allergies, medications, precautions)

___ FULL PHYSICAL ACTIVITY

___ RESTRICTIONS (SPECIFY)

DATE OF EXAM

MONTH		DAY		YEAR	

PHYSICIAN SIGNATURE

PHYSICIAN NAME (Print)

ADDRESS

TELEPHONE

TYPE OF FACILITY

Stamp/License #

TYPE OF FACILITY

___ HHC Child Health Clinic	___ Private Practice	___ School Based Clinic
___ HHC Communicare Clinic	___ HMO/Comm. Health Center	___ Other _____
___ HHC Hospital Ambulatory Care Clinic	___ Volunteer Hospital Ambulatory Care Clinic	_____

ASTHMA

Has the student ever been diagnosed with:

___ Asthma

___ Asthmatic, wheezy or chronic bronchitis

___ No Asthma ___ Reactive airways disease

In the past 12 months has the student had any symptoms of asthma, including wheeze, cough with exercise, or dry cough at night without a cold?

___ YES ___ NO

In the past 12 months has the student been prescribed any of the following medications for this condition?

___ Oral bronchodilators ___ Oral steroids

___ Inhaled anti-inflammatories (cromolyn, nedocromil, steroids)

___ Inhaled, short acting bronchodilators

___ None