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 APT CITY STATE ZIP

Place of Birth

___NYC ___NYS ___OTHER_____

ETHNICITY:

ASIAN___ BLACK ___ HISPANIC___ NATIVE AMERICAN ___ SOUTH PACIFIC ISLANDER ___ WHITE ___ OTHER_____

___PARENT
___GUARDIAN
___FOSTER PARENT

LAST NAME FIRST NAME TELEPHONE

HOME: ( ) - WORK: ( ) -

HAS THE STUDENT HAD, OR NOW HAVE ANY OF THE FOLLOWING:

1 __ASTHMA
2 __ALLERGIES
_____
3 __CONGENITAL HEART DISEASE
4 __CONVULSIONS
5 __DIABETES
6 __CANCER
7 __TUBERCULOSIS
8 __ORTHOPEDIC PROBLEMS
9 __VISION PROBLEMS
10 __HEARING PROBLEMS
11 __SPEECH PROBLEMS
12 __HOSPITALIZATIONS _____
13 __SURGERY - WHAT KIND _____
14 __SERIOUS ILLNESS _____
15 __SERIOUS ACCIDENTS _____
17 __OTHER PROBLEMS OR LIMITATIONS _____

ASTHMA

In the past 12 months has your daughter had any of the following symptoms?

___ Wheezing or whistling sound in the chest?
___ Coughing with exercise?
___ Dry coughing at night when she does not have a cold?
___ None

In the past 12 months has your daughter taken any medicines for these symptoms?

___ Yes ___ 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?

___ Yes ___ 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
HEMATOCRIT/HEMOGLOBIN	___/___/___	ẑẑ/ẑẑ.ẑ
HGB ELECTROPHORESIS	___/___/___	_____
OTHER	___/___/___	_____

	DATE	RESULTS
URINALYSIS	_____	_____
AUDIO/SWEEP	_____	_____
THRESHOLD	_____	_____

VISION

RIGHT	/	/
LEFT	/	/
BOTH	/	/

DATE ___/___/___

___/___/___

FUSION **P F** ___/___/___

TB:

MANTOUX DATE RESULTS

(PPD) IMPLANTED _____ ____NEGATIVE _____ MM

READ _____ ____POSITIVE _____ MM

	DATE	RESULTS
CHEST X-RAY	___/___/___	_____
BCG	___/___/___	__YES __NO

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. _____
2. _____
3. _____

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 #**

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

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 _____