ELEMENTARY HEALTH APPRAISAL

Name of Student ______________________________ Date of Birth ______________

Address ______________________________ Grade ______________

School ______________________________ Teacher ______________

IMMUNIZATIONS (if indicated) ______________ ______________ ______________

TYPE DATE TYPE DATE TYPE DATE

DATE OF EXAM ______________________________

HEIGHT __________ WEIGHT __________ SEX __________ BLOOD PRESSURE __________ RESTING PULSE __________

HEAD __________ NECK __________ MOUTH __________ TEETH (APPLIANCE) __________

THROAT __________ CHEST __________ HEART __________ GENITALIA __________

ABDOMEN ______________________________ EXTREMITIES ______________________________

BACK ______________________________ SCOLIOSIS SCREENING ______________________________

SKIN ______________________________ NEUROLOGICAL ______________________________

AUDIOMETRY:

AS 500	1000	2000	4000	Hz

AD 500	1000	2000	4000	Hz

VISUAL ACUITY UNCORRECTED: (if indicated)

OS	OD	OU	COLOR DISCRIMINATION

VISUAL ACUITY CORRECTED: (if indicated)

OS	OD	OU	COLOR DISCRIMINATION

URINALYSIS:				PPD		HGB/HCT	
SPEC.GRAV.	PRO.	GLUC	MICRO	DATE	RESULT	DATE	RES

ANY RESTRICTION OF ACTIVITIES: YES ________ NO ________ (Please check one)

IF YES, EXPLAIN: ______________________________

____

______________________________ M.D. STAMP

(SIGNATURE OF PHYSICIAN)

______________ ______________

(DATE) (TELEPHONE NUMBER)