THREE VILLAGE CENTRAL SCHOOL DISTRICT
Setauket, New York 11733
ELEMENTRY HEALTH APPRAISAL

Name of Student _____ Date of Birth _____

Address _____ Grade _____

School _____ Teacher _____

IMMUNIZATION: (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 _____

SKIN _____ NEUROLOGICAL _____

AUDIOMETRY:

AS 500	1000	2000	40000	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	RESULT

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

IF YES, EXPLAIN:

_____

_____ M.D. STAMP
SIGNATURE OF PHYSICIAN

_____ _____
DATE TELEPHONE NUMBER

REVISED 2/10