

**Visitation School**  
 Student's Health History  
 To be completed before pupil is examined by physician

Please complete both sides.

*The information contained in this form is confidential.*

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Father or Guardian: \_\_\_\_\_ Mother or Guardian: \_\_\_\_\_

Physician: \_\_\_\_\_

Health History: Major illness, Operations, Injuries or Problems \_\_\_\_\_

Personal and Family History:

- Has the student ever had rheumatic fever or a heart murmur? \_\_\_\_\_
- Has the student ever had a nervous breakdown, convulsions, or mental disease? \_\_\_\_\_
- Has any member of his family ever had tuberculosis, diabetes, asthma, mental, or nervous disorder? \_\_\_\_\_
- Can the student take full course in physical training, calisthenics, and swimming? \_\_\_\_\_
- Has he your permission to participate in intercollegiate or intramural athletics such as football, basketball and baseball? \_\_\_\_\_

**Immunizations**

Enter the Month, Day and Year for all vaccines the pupil received. (Do NOT use (√) or (X)).

Type of Vaccine	1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose	4 <sup>th</sup> dose	5 <sup>th</sup> dose
Diphtheria, Tetanus, and Pertussis (DtaP, DTP)					
Diphtheria and Tetanus (DT) – pediatric formulation (<7 yrs)					
Tetanus and Diphtheria (Td) – adult formulation (>7 yrs)					
Polio (IPV, OPV)					
Measles, Mumps, & Rubella (MMR) (minimum age: 12 mos.)					
Hepatitis B (HBV)*					
Varicella (Chickenpox)**					
Pneumococcal Conjugate (PCV)***					
Haemophilus influenzae type b (Hib)***					

\*Hepatitis B is required for kindergarten and 7<sup>th</sup> grade.

\*\*Varicella vaccine will be required starting fall 2004.

\*\*\*PCV and Hib vaccine are recommended only for children through age 4 years.

*Note for all school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTP+Hib, Hib+HBV) in each applicable space.*

Other: \_\_\_\_\_

Tuberculin Test Date: \_\_\_\_\_ Negative \_\_\_\_\_ Positive \_\_\_\_\_

Type: \_\_\_\_\_

**Health Examination**

To be completed by physician

Please complete **both** sides.

Name \_\_\_\_\_ Grade \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Scoliosis \_\_\_\_\_

Hemoglobin \_\_\_\_\_ Urine \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Eyes**

Glasses worn Yes \_\_\_\_\_ No \_\_\_\_\_  
Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_  
Development Normal Yes \_\_\_\_\_ No \_\_\_\_\_

**Ears**

Hearing Aid Worn Yes \_\_\_\_\_ No \_\_\_\_\_  
Hearing R \_\_\_\_\_ L \_\_\_\_\_  
Speech Normal Yes \_\_\_\_\_ No \_\_\_\_\_

List any significant findings of the complete medical examination: \_\_\_\_\_

\_\_\_\_\_

Recommendations Regarding Treatment and correction of Deficits: \_\_\_\_\_

\_\_\_\_\_

Any Condition Which May Result in an Emergency? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Specify: \_\_\_\_\_

\_\_\_\_\_

What Learning Problems, if any, Should be Watched for: \_\_\_\_\_

\_\_\_\_\_

What Emotional Problems, if any, Should be Watched for: \_\_\_\_\_

\_\_\_\_\_

Is There a Condition Which May Limit Participation in:

- A. Classroom Activity? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Physical Education? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. competitive Sports? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Specify: \_\_\_\_\_

Is this student adequately immunized? Yes \_\_\_\_\_ No \_\_\_\_\_ (See reverse side)

If not, please advise parent to bring the student's immunizations up to date at this time and to have them recorded on this form.

Comments and Recommendations: \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_ M.D.

Address \_\_\_\_\_ Phone \_\_\_\_\_