

MUST BE FILLED OUT COMPLETELY

Immaculate Heart of Mary School

Health Form

Grade/Homeroom _____

Physical Assessment

Year Enrolled _____

Child's Name	Gender	Age	Birthdate
Parent/Guardian	Parent/Guardian Address	Home Phone Number	

Objective Data

Height	Weight	Blood Pressure	Pulse
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Immunization Record					
Type	Date (MUST include month/date/year)				
DTaP DPT or DT					
DT/Td					
Polio					
MMR					
Hepatitis B					
Varicella					
HIB					
Tuberculin Test					
Rotavirus					
Other					

Screening Tests

Vision	Date	Hearing	Date
Per ODH: pass line is 20/30;each eye		Pure Tone Testing: Per ODH@	
Distance Acuity	Right _____ Left _____	20 decibels;1000,2000,4000 Hz	
Farsightedness	Pass _____ Fail _____	Right Ear	Pass _____ Fail _____
Muscle Balance	Pass _____ Fail _____	Left Ear	Pass _____ Fail _____
Color Deficit?	Pass _____ Fail _____	Child wears hearing aid?	Yes _____ No _____
Stereopsis	Pass _____ Fail _____	Tested with hearing aid?	Yes _____ No _____
Child Wears Glasses?	Yes _____ No _____	Referral Made?	Yes _____ No _____
Tested with glasses?	Yes _____ No _____	Other test(specify) _____	
Referral Made?	Yes _____ No _____		
Specify Test Equipment	_____		

Speech Assessment

___ Child has no discernible speech problem

___ Child has possible problem with: ___Articulation ___Rhythm ___Voice ___Language

Speech evaluation is recommended: ___Yes ___No

Allergies (Please list and describe allergies or reactions)
Medication/Drugs
Foods/Plants/Animals/Other
Recommended treatment if allergy is severe(life threatening allergies require an IHP)

Injuries, Illness & Hospitalization		
Injuries/Illness/ Hospitalizations	Age	Please explain

Medications	Name	Dose & Frequency	What is Medication For?

Activities & Limitations

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

- Can the child participate fully in the following activities :
- Classroom and academic activities Yes No
 - Physical education classes Yes No
 - Competitive Athletics Yes No
 - Contact & collision sports Yes No

Specify any limitations:
 This child is essentially within normal limits? Yes No- Explain:

Physical Examination (Must be within the last 12 months)

Physician Signature: _____ Date _____

Physician's Printed Name _____

Address _____

_____ Phone _____

IMMACULATE HEART OF MARY SCHOOL

ORAL ASSESSMENT

Child's Name _____ Age _____ Birthdate _____

The following services have been performed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Examination by dentist | <input type="checkbox"/> Orthodontic assessment | <input type="checkbox"/> Oral screening |
| <input type="checkbox"/> Dental sealants | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Fluoride application |
| <input type="checkbox"/> Oral prophylaxis (cleaning) | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Prescription for fluoride supplements |

The following oral hygiene instruction was provided:

- | | |
|--|---|
| <input type="checkbox"/> Toothbrushing | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing | <input type="checkbox"/> Home/school use of fluoride mouthwash |

The following statements are applicable:

- No apparent care needed at this time.
- All necessary preventive services have been performed .
- No restorative services are required at this time.
- Further treatment is indicated. (See comments)
- Further appointments have been arranged.

Comments:

Examiner's Signature _____ Date _____

Examiner's printed name _____

Address _____

_____ Phone _____