

ASSUMPTION SCHOOL STUDENT HEALTH APPRAISAL – Pre-k through 2nd Grade

Name: _____

Grade: _____

D.O.B.: _____ Sex: M F

IMMUNIZATION RECORD (may attach copy)

Vaccine Type	Disease Date	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr	Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS – DTP *If DT or Td, indicate at top of box							
POLIO ORAL POLIO VACCINE (OPV) *If Salk vaccine, indicate (IPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)		#1	#2		MMR Serology	Date:	Titer:
MEASLES					Measles Serology	Date:	Titer:
RUBELLA					Rubella Serology	Date:	Titer:
MUMPS					Mumps Serology	Date:	Titer:
HAEMOPHILUS B (HIB) **							
HEPATITIS B						Date:	Titer:
VARICELLA						Date:	Titer:
Other (Specify)							
TB Screening (Mantoux Test)			Chest X-Ray			Therapy	
Date	Date	Date	Date	Normal	Abnormal	Case <input type="checkbox"/>	Reactor <input type="checkbox"/>
Tested _____	_____	_____	_____	_____	_____	Date Started: _____	_____
Read _____	_____	_____	_____	_____	_____	Date _____	_____
Result(MM) _____	_____	_____	_____	_____	_____	Completed: _____	_____

HEALTH HISTORY

Allergies _____

Chronic Illnesses _____

Childhood Illnesses _____

Disabilities _____

Hospitalization and/or Surgery _____

Injuries _____

Medication _____

Attention Deficit _____ Auditory Deficit _____

Comments/Recommendations _____

PHYSICAL EXAMINATION

Blood Pressure _____ Vision: Right _____ Left _____

N = Normal R = Referred T = Under tx. C = Comments

Ears (otoscopic)	Eyes	Lymph Glands	Thyroid
Nose	Throat	Teeth – Mouth	Heart
Lungs	Abdomen	Hernia	Genital – Urinary
Orthopedic	Posture	Feet	Skin (non-comm)
Nutrition	Nervous System	Speech	Other
General appearances	Height	Weight	B.P.

Physicians Signature _____ Date of Exam _____

Physician's Printed Name _____

Physician's Printed Office Address _____