# ASSUMPTION SCHOOL STUDENT HEALTH APPRAISAL

Grades Pre K through 8 if not participating in a School Sport

Name: _____ D.O.B.: _____
Last First Middle

Sex (circle): M F Grade: _____

Weight_____ Height_____ Blood Pressure_____

Vision: Right_____ Left_____

N = Normal A = Abnormal T = Under Treatment

Eyes_____
Ears _____
Nose _____
Throat _____
Neck _____
Teeth/Mouth _____
Heart _____
Lungs_____
Abdomen _____
_____
Genitourinary _____
Orthopedic/Chest Contour _____
Posture_____
Extremities _____
Skin _____
Neuromuscular _____

Speech _____
General Appearance _____
Hernia _____
Scoliosis _____
Diabetes _____
Injuries _____
Operations _____

Latest Immunization Dates OR
Please Attach Immunization Record:
DPT/DT Booster _____
Polio Booster _____
TB – Last Test: Type _____
Date _____
Results_____
MMR Booster _____

Does the child have any allergies? If YES, please list:

To food: Y N _____
To medication: Y N _____
To bee stings: Y N _____

Does the child wear glasses or contacts? Y N _____

Does the child have asthma or RAD? Y N _____

Is student on any medication?_____ If so, what?_____ Dosage_____

Has the student had any medical problems during the past year? Y N

If so, what were they? _____

**May the student participate in school activities or sports?**

Yes _____ No _____ Explanation: _____

Remarks and Recommendations: _____

Physician's Signature _____ Date of Exam _____

Physician's Printed Name _____

Physician's Printed Office Address _____

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