UNION COUNTY TEAMS CHARTER SCHOOL

Union County TEAMS Charter School and High School/College Academy

20__ - 20___ HEALTH SERVICES/HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

Dear Parent/Guardian: _____

NOTE: ALL PHYSCIALS MUST BE CURRENT. Please present this form to your physician at the time of your examination. Upon completion, please return to the school.

(ATTACH UPDATED IMMUNIZATION RECORD)

HEIGHT: _____ WEIGHT: _____ B.P.: _____ PULSE: _____ URINE: _____ PROTEIN: _____ SUGAR: _____

VISION: RIGHT: _____ LEFT: _____ BOTH: _____ GLASSES: RIGHT: _____ LEFT: _____ BOTH: _____

PHYSICAL FINDINGS	NORMAL	ABNORMAL	SPECIFY AND RECOMMEND
EYES			
VISION			
COLOR PERCEPTION			
EARS – OTOSCOPIC			
HEARING: RIGHT			
HEARING: LEFT			
TEETH/MOUTH			
NOSE			
THROAT			
LYMPH GLAND			
THYROID			
HEART			
LUNGS			
ABDOMEN			
HERNIA			
GENITO-URINARY			
ORTHOPEDIC (STRUCTURAL)			
SCOLIOSIS SCREENING			
SKIN			
NUTRITION			
NERVOUS SYSTEM			
SPEECH			
OTHER			

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