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			

-over-

STUDENT’S NAME: ____

DATE OF MOST RECENT TUBERCULIN TEST (MANTOUX): ___________________________________

RESULT: ___________________________________ FOLLOW-UP: ___________________________

DATES OF MOST RECENT IMMUNIZATION GIVEN, OR DATES OF ALL IMMUNIZATIONS FOR NEWLY REGISTERED STUDENTS ENROLLING IN PRE-K OR KINDERGARTEN:

POLIO: ___________________ DTP: ______________________ DT: ______________________

MEASLES: ________________ RUBELLA: ________________ MUMPS: _________________

OTHER: ____

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PLEASE LIST ANY HEALTH PROBLEMS WHICH MAY INTERFERE WITH THE STAFF MEMBER’S EDUCATIONAL PROGRAM OR LIMIT HIS/HER PARTICIPATION IN THE REGULAR SCHOOL PROGRAM AND INDICATE ANY RESTRICTIONS:

_____________________________________ _______________________________________

DATE OF EXAMINATION PHYSICIAN SIGNATURE

PRINTED NAME AND ADDRESS OF PHYSICIAN:

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