



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 PHYSICALS 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-

SCHOLAR'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 SCHOLARS 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 SCHOLAR'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:

