

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT HEALTH EXAMINATION

Student's Name: _____ School: _____ Grade: _____ Room: _____

PHYSICIAN COMPLETE (*Actual Readings)

* Height:	* Blood Pressure:	* Pulse:
* Weight:	Abdomen:	
Eyes:	Hernia:	
Ears:	Heart:	
Vision: w/glasses _____ w/o glasses _____	Lungs:	
Nose & Throat:	Urinalysis: Sugar _____ Protein _____ Blood _____	
Mouth & Teeth:	Orthopedic: * Scoliosis	
Skin:	Allergies: _____ Seasonal _____ Life Threatening _____ Asthma _____ Medication	

* BODY MASS INDEX*:		
WEIGHT STATUS CATEGORY (BMI) PERCENTILE:		
_____ Less than 5%	_____ 5th through 49th%	_____ 50th through 84th%
_____ 85th through 94th%	_____ 95th through 98th%	_____ 99th and higher

Specify current diseases: Asthma Diabetes type 1 Diabetes type 2 Cholesterol Hypertension

May student participate in physical education activities? _____

Recommendations for adjustment of school program: _____

Does student require medication? Yes No If yes, please specify: _____

Physician's Signature and Stamp: _____

Actual Date of Physical: _____

IMMUNIZATIONS AND TESTS

IMMUNIZATIONS	DATE-1 ST DOSE	DATE -2 ND DOSE	DATE-3 RD DOSE	DATE-1 ST BOOSTER	DATE-2 ND BOOSTER
Polio					
Dtap					
Tdap or TD					
MMR					
Measles					
Mumps					
Rubella					
Hib					
Hep B					
Hep A					
Varicella					
Pneumococcal					
PPD (Tuberculin)					
Meningococcal Vaccine					
Other					

Legal Requirements for immunization waived because of: Religious Exemption _____ Medical Exemption _____

TO BE COMPLETED BY PARENT OR GUARDIAN

School Student is attending: _____

Teacher _____ Grade _____ Room #: _____

Student's Name: _____ Home Phone #: _____

Cell/Work: (mother/guardian): _____ (father): _____

Address: _____

**YOUR CHILD MUST RETURN A PRIVATE PHYSICIAN'S EXAMINATION FORM BY OCTOBER 1st.
OTHERWISE HE/SHE WILL HAVE A SCHOOL HEALTH APPRAISAL.**

1. Has your child, during the past year, had any illness, injury, or operation? If so, please specify, with dates:

2. Has your child received any immunization or tests during the past year? If so, please specify dates and type of immunization or tests not recorded on reverse side of form:

3. Is your child under medical supervision for allergies? If so, please specify type, symptoms and treatment:

4. Does your child take any medication on a regular basis? (**Self-Medication in school is illegal according to State Education Law.**) If your child must take any medication during the school hours, please consult with your school nurse regarding procedures:

5. Do you have any other information which would aid the school in a better understanding of your child?

6. Please list two neighbors who will be available to be called in case of illness or emergency:

NAME	RELATIONSHIP	ADDRESS	PHONE #
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NAME	RELATIONSHIP	ADDRESS	PHONE #
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TO BE CALLED IN CASE OF EMERGENCY:

7. Physician: _____ Phone #: _____

To the best of my knowledge, the above information is correct:

SIGNATURE: _____ DATE: _____