VALLEY CHRISTIAN

Health Exam Form

A Health Exam Form MUST BE COMPLETED AND RETURNED within two weeks of the beginning of school starting. A physical is required within one yyear prior to starting our school.

To be filled in by parent or guardian before the time of the examination. (Please print plainly with ink.)

Pupil's Name:______________________________ Birth:____________ Sex: M______ F_____
Last First

Address ____ Phone ( )__________
Street City Zip

Student's Physician ____ Phone ( )__________
Last First

Birth, infancy and preschool history: Record unusual problems, complication during pregnancy, e.g. hard labor, febrile episodes, convulsions, accident, operation, exposure to TB, behavior difficulties, problems of sleep and rest; poison injection, etc.

____

Development	Age	Development	Age
Walked alone	__________	Bowel control	__________
Talked words	__________	Bladder control	__________
Sentences	__________	Dressed self	__________

Past history of illnesses, state the month and year in which the child had any of the following.

Communicable Diseases		Other Diseases		Other Conditions
Chicken Pox	______/______	Asthma	______/______	Constant cough__________
Diphtheria	______/______	Diabetes	______/______	Fainting spells__________
German measles	______/______	Hay fever	______/______	Frequent colds__________
Poliomyelitis	______/______	Kidney trouble	______/______	Frequent sore throats______
Scarlet fever	______/______			Frequent urination________
Whooping cough	______/______	Pneumonia	______/______	Hearing difficulty________
Mumps	______/______	Rheumatic fever	______/______	Tires easily__________
				Vision difficulty__________
		Tonsillitis	______/______	Frequent headaches_______
				Frequent stomach aches____
				Frequent ear infections_____
				Allergies (list) be sure to Include "bee sting" allergy.
				______________________
				______________________
				Attention Deficit Disorder
				______________________
				______________________

Other information of value to the teacher, e.g. current medication or therapy.

____
____
____

Glasses: ______Yes ______ No

PHYSICAL

TO BE COMPLETED BY PHYSICIAN Pupil's Name_______________________________

Parent(s) present: Yes________ No_______

Vision: without glasses: right eye 20/_______ left eye 20/_______
with glasses: right eye 20/_______ left eye 20/_______
color vision:________________________________ test used:________________________

Hearing: right ear:___________________________________ left ear:________________________

Eyes	________ Normal	________ Defect	________________________
Ears	________ Normal	________ Defect	________________________
Nose	________ Normal	________ Defect	________________________
Throat	________ Normal	________ Defect	________________________
Lymph Nodes	________ Normal	________ Defect	________________________
Heart	________ Normal	________ Defect	________________________
Lungs	________ Normal	________ Defect	________________________
Abdomen	________ Normal	________ Defect	________________________
Blood Pressure	________ Systolic	________ Diastolic	________________________
Genitals	________ Normal	________ Defect	________________________
Posture	________ Normal	________ Defect	________________________
Extremities	________ Normal	________ Defect	________________________
Nervous System	________ Normal	________ Defect	________________________
Skin	________ Normal	________ Defect	________________________
Nutrition	________ Normal	________ Defect	________________________
Musculature	________ Normal	________ Defect	________________________
Emotional	________ Normal	________ Defect	________________________
Other:			
_______________	________ Normal	________ Defect	________________________
_______________	________ Normal	________ Defect	________________________

Hemoglobin____
Urinalysis____
Findings and recommendations____
____
____

Immediate medical referral: Yes_______ No________ Dental referral: Yes________ No_______

Unlimited activity___________________________________ Limited activity________________________

IMMUNIZATIONS

Along with this health form, please present your child's personal immunization record. In most cases, it will be a yellow California Immunization Record or similar form given to the parent by the doctor or clinic, which shows the date each required vaccine dose was received. Please examine the card before submitting it to make sure dates are correct and that these dates can easily be read. For students entering TK and Kindergarten, these dates will be transcribed onto the blue California School Immunization Record, which will become part of the child's mandatory cumulative folder.

____M.D. ___________________________________
Examining Physician Date of Examination

REV.07/01/20