YONKERS PUBLIC SCHOOLS

Student Health History and Physical Examination

Student's Name: _____ **DOB:** _____ ☐ M ☐ F

Address: _____ **SCHOOL** _____ **GRADE** ___

Hospitalizations/Surgery: _____

_____

_____

Medications: _____

Ht: _____ **Wt:** _____ **BMI:** _____ **BP:** _____/_____

Vision: L____/____ R____/____ **Hearing:** _____ **Scoliosis:** ☐ Yes ☐ No

Allergies: Foods_____ Meds _____

Other _____ Anaphylaxis _____ EPI pen ☐ Yes ☐ No

Asthma: ☐ Active ☐ Inactive ☐ Asthma Action Card® **Diabetes:** ☐ Type 1 ☐ Type 2 ☐ Pump

	WNL	ABNORMAL: comments
Skin		
Skeletal		
HEENT		
Neck		
Lung		
Heart		
Abd/ GI		
GU		
Neuro		

Impression: _____

_____

☐ **Full Physical Activity**

☐ **Restricted Physical Activity**

Vaccine	1st	2nd	3rd	4th	5th
OPV/IPV					
DPT/DTaP					
Td/DT					
Hib					
MMR					
HepB					
Varicella					
Meningitis					
HepA					

PPD:
Date administered:_____
Results: _____ mm
CXR: ____ **Prophylaxis:** ____

☐ **Varicella Disease:**
Date:_____

STAMP

Physician Signature _____ **Date** _____

Address: _____

Revised 2/2006 / no