

SCHOOL HEALTH EXAMINATION RECORD

1. CHAPEL HILL CHRISTIAN SCHOOLS

Grade _____

Student's Name : Last First Middle	Home Address:	Home Phone:	Student Birth Date:
Father or Guardian's Name:	Place of Employment:	Work Phone:	
Mother or Guardian's Name:	Place of Employment:	Work Phone:	
Physician's Name:	Address:	Office Phone:	
Dentist Name:	Address:	Office Phone:	

II. Is there anything about your child that the teacher needs to know to understand him/her better?

III. List any diseases and other serious illness, injuries, or health conditions that your child has had and give dates (year only):

IV. Does any relative or anyone in the home have tuberculosis, diabetes, or ongoing illnesses? Describe:

V. List all allergies and prescription medications your child currently takes:

Dentist's Report

Please check off which of the following services have been performed:

- Radiographs
- Oral Prophylaxis
- Fluoride Treatments
- Restorations

Please check the following statements that are applicable:

- All necessary services have been performed.
- No restorative services are requested at this time.
- Further treatment is indicated.
- Future appointments have been arranged.

Comments:

Date _____

Signature of Examining Dentist

Physician's Report

Immunizations

	Date	Date	Date	Date	Date
DPT/DTaP					
Td					
Polio Sabin (tri)/OPV/IPV					
MMR					
Chicken Pox					
Hepatitis B					
HIB					
Other					

Screening Test:

	Date	Result	
Muscle Balance			
Farsightedness			
Color			
Distance Acuity			
Hearing			
Tuberculin	Date	Test	Result

Physical Assessment:

Check one:

- Entirely within normal limits.
- Abnormalities are as follows:

Is there any reason why the student cannot carry out a full program of school work?

- Yes No

Date: _____

Signature of Examining Physician

Please note that the shaded areas signify a requirement by Ohio law. Other areas are recommend, but not required.