

To the Health Care Provider: Please complete and sign.

\_\_\_\_\_ has had a complete history and physical exam on \_\_\_\_\_  
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record																																																																																																															
Note: * Mandated Screening/Test under Connecticut State Law																																																																																																																		
* Height:		BMI:	<b>Vaccine (Month/Day/Year)</b> Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only. <table style="width:100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th></th> <th>Dose 1</th> <th>Dose 2</th> <th>Dose 3</th> <th>Dose 4</th> <th>Dose 5</th> <th>Dose 6</th> </tr> </thead> <tbody> <tr> <td>DTP</td> <td>"</td> <td>"</td> <td>"</td> <td>"</td> <td></td> <td></td> </tr> <tr> <td>DTP/Hib</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DTaP</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DT/Td</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OPV</td> <td>*</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>IPV</td> <td>*</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>MMR</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Measles</td> <td>*</td> <td>*</td> <td></td> <td></td> <td colspan="2">Booster for entry into K and 7th grade</td> </tr> <tr> <td>Mumps</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rubella</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HIB</td> <td>"</td> <td></td> <td></td> <td></td> <td colspan="2">Students under age 5</td> </tr> <tr> <td>Hep B</td> <td>"</td> <td>"</td> <td>"</td> <td></td> <td colspan="2">Req. for entry into K and 7th grade.</td> </tr> <tr> <td>Varicella</td> <td>*</td> <td>*</td> <td></td> <td></td> <td colspan="2">Students born 1/1/97 or later. Required for 7th grade entry.</td> </tr> <tr> <td>PCV</td> <td></td> <td></td> <td></td> <td></td> <td colspan="2">Pneumococcal conjugate vaccine.</td> </tr> </tbody> </table>								Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	DTP	"	"	"	"			DTP/Hib							DTaP							DT/Td							OPV	*	*	*				IPV	*	*	*				MMR	*	*					Measles	*	*			Booster for entry into K and 7th grade		Mumps	*	*					Rubella	*	*					HIB	"				Students under age 5		Hep B	"	"	"		Req. for entry into K and 7th grade.		Varicella	*	*			Students born 1/1/97 or later. Required for 7th grade entry.		PCV					Pneumococcal conjugate vaccine.	
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* Weight:		* Postural:																																																																																																																
* Blood Pressure:		<input type="checkbox"/> Normal																																																																																																																
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* HCT/HGB:		Min. _____																																																																																																																
Urinalysis:		Slight _____																																																																																																																
* Gross dental:		Mod. _____																																																																																																																
Lead (Date/Result)		Marked _____																																																																																																																
		<input type="checkbox"/> Referral																																																																																																																
TB and Other Test Results (Sickle Cell, etc.)																																																																																																																		
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																		
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* Vision/ Type of Screening	* Auditory/ Type of Screening																																																																																																																	
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<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified																																																																																																																		
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II																																																																																																																		
<input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex																																																																																																																		
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder																																																																																																																		
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____																																																																																																																		
			<b>Disease Hx of above</b> _____ (Specify) _____ (Date) _____ (Confirmed by)																																																																																																															
			<b>Exemption</b> Religious _____ Medical: Permanent _____ Temporary _____ Date _____ Recertify Date _____ Recertify Date _____ Recertify Date _____																																																																																																															

This student has the following problems which may adversely affect his or her educational experience:

Vision  Auditory  Speech/Language  Physical Dysfunction  Emotional/Social  Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): \_\_\_\_\_

- This student may participate fully in the school program, including physical education activities.
- This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* \_\_\_\_\_
- Yes  No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
- I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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