



St. Edmund's Academy

## HEALTH ASSESSMENT FORM

Required for:

- \* ALL new students
- \* Students entering Kindergarten
- \* Students entering 6<sup>th</sup> Grade
- \* Extracurricular Athletics participants (exam date MUST be within 1 year for sports eligibility)

STUDENT NAME \_\_\_\_\_

GRADE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

SEX: M \_\_\_\_\_ F \_\_\_\_\_

Date of Examination: \_\_\_\_\_

|  |                       |          |              |                   |
|--|-----------------------|----------|--------------|-------------------|
| Pulse _____<br>Respiration _____<br>B.P. _____<br>Height _____ Weight _____<br>Visual Acuity O.D. O.S. (c or s lenses) _____   | <b>Health History</b> |          |              |                   |
|  | Normal                | Abnormal | Not Examined | Describe Findings |
| General Appearance   |                       |          |              |                   |
| B.M.I. (Body Mass Index)   |                       |          |              |                   |
| Skin   |                       |          |              |                   |
| Eyes   |                       |          |              |                   |
| Ears (canals and TMs)  |                       |          |              |                   |
| Nose, Mouth, Throat  |                       |          |              |                   |
| Teeth, Gingiva   |                       |          |              |                   |
| Neck, Thyroid  |                       |          |              |                   |
| Chest (breasts)  |                       |          |              |                   |
| Lungs  |                       |          |              |                   |
| Heart  |                       |          |              |                   |
| Abdomen (hernia)   |                       |          |              |                   |
| Genitalia  |                       |          |              |                   |
| Joints, Muscles  |                       |          |              |                   |
| Posture, Gait  |                       |          |              |                   |
| Neurological   |                       |          |              |                   |
| Spine  |                       |          |              |                   |
| <b>Immunizations:</b> DPT DTaP _____<br>(Please enter Tdap _____ Td _____<br>date for each OPV/IPV _____<br>dose in the Hepatitis B #1 _____ #2 _____ #3 _____<br>spaces) MMR #1 _____ #2 _____<br>Varivax #1 _____ #2 _____ or date of Varicella disease _____<br>Meningococcal _____ |                       |          |              |                   |
| * Please list any additional non-required vaccines on back of page.  |                       |          |              |                   |

Should this child have restrictions on play or physical education activities? NO YES

Examiner's Signature: \_\_\_\_\_

Practice Contact Information:

**Recommended Vaccines (Please indicate date for each dose in spaces)**

|             |       |       |       |       |       |       |
|-------------|-------|-------|-------|-------|-------|-------|
| Hepatitis A | _____ | _____ |       |       |       |       |
| HPV         | _____ | _____ | _____ |       |       |       |
| Hib         | _____ | _____ | _____ | _____ |       |       |
| Pevnar      | _____ | _____ | _____ | _____ |       |       |
| Influenza   | _____ | _____ | _____ | _____ | _____ | _____ |
|             | _____ | _____ | _____ | _____ | _____ | _____ |
|             | _____ | _____ | _____ | _____ | _____ |       |