BLESSED TRINITY
CATHOLIC SCHOOL
HEALTH SERVICES
HISTORY AND PHYSICAL EXAMINATION FORM

PARENT/GUARDIAN: Please complete this section prior to seeing physician.

Student's Name (Last)_____(First)_____(Initial)_____ Birthdate_____
Parent's/Guardian's Names_____Address_____
Phone_____Grade_____Age_____School (if known)_____

HEALTH HISTORY - Enter Date(s)

ALLERGY (specify)		NEUROLOGIC (specify)		Current Health Concerns
				(Specify)
ASTHMA		SEIZURES (specify)		
CONGENITAL DEFECT (specify)				
		ORTHOPEDIC (specify)		
DIABETES				
CHICKEN POX		PREMATURE BIRTH		
INFECTIONS		SURGERY (specify)		
EAR				
STREP THROAT		T & A		
FREQUENT COLDS		PE TUBES (ears)		
OTHER (specify)		MEDICATIONS (specify)		
		OTHER		Parent Signature:
SERIOUS ACCIDENTS (specify)				
				Date:

PHYSICIAN: PLEASE COMPLETE THIS SECTION

Test - Indicate Normal (N) Abnormal (Ab) If Abnormal, include comments below.		Measurement Give Exact Value		Examination - Indicate Normal (N) or Abnormal (Ab). If Abnormal, include comments below.			
	N/Ab				N/Ab		N/Ab
Tuberculin		Blood Pressure		Skin/Lymph		Lungs	
Hemoglobin/Hematocrit		Height		Eyes		Abdomen	
Urine		Weight		Ears		Genito-urinary	
Lead		Vision: R 20/	L 20/	Nose		Orthopedic	
Other		w/glasses Yes	No	Mouth		Scoliosis	
		Hearing: R	L	Throat		Neurological	
		w/hearing aid Yes	No	Neck		Speech	
				Heart		Other (specify)	

1. Physical activities should be restricted.
   No_____ Yes_____ If yes, specify:_____
2. There is a condition that may result in an emergency.
   No_____ Yes_____ If yes, specify:_____
3. There is a condition that may interfere with learning.
   No_____ Yes_____ If yes, specify:_____

On-going therapies and medications - specify type and dose.

PROBLEMS AS INDICATED ABOVE

1._____
2._____
3._____

PLANS AND/OR RECOMMENDATIONS

Physician's Signature_____Date of Examination_____Phone_____
Physician's Name_____Address_____
(Please print or type)

1/92 Forms