SUMMIT CHRISTIAN ACADEMY - HEALTH RECORD

Health Care Provider's Examination

Name _____ □ Male □ Female Date of Birth: _____

Medical History _____

Current Health Issues

Y N

□ □ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen: □ Yes □ No

□ □ Asthma: Asthma Action Plan □ Yes □ No *(Please attach)*

□ □ Diabetes: □ Type I □ Type II

□ □ Seizure disorder: _____

□ □ Other *(Please specify)* _____

Current Medications (if relevant to the student's health and safety). *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination

Hgt: _____(____%) Wgt: _____(____%) BMI: _____(____%) BP: _____

□ General _____ □ Lungs _____ □ Extremities _____

□ Skin _____ □ Heart _____ □ Neurologic _____

□ HEENT _____ □ Abdomen _____ □ Other _____

□ Dental/Oral _____ □ Genitalia _____

Screening	Pass	Fail		Pass	Fail		Pass	Fail
Vision: Right Eye	□	□	Hearing: Right Ear	□	□	Postural Screening:	□	□
Left Eye	□	□	Left Ear	□	□	(Scoliosis/Kyphosis/		
Stereopsis	□	□				Lordosis)		

The examination was normal: □ Yes □ No

The student has the following problems that may impact their educational experience:

□ Vision □ Hearing □ Speech/Language □ Fine/Gross Motor Deficit

□ Emotional/Social □ Behavior □ Other □ None

Comments/Recommendations: _____

□ Yes □ No **This student may participate fully in the school program, including physical education and sports.**

If no, please list restrictions: _____

□ Yes □ No **Immunizations are complete.**

If no, give reason.

_____ _____

Signature of Examiner *Circle:* MD, DO, NP, PA Date

_____

Please print name of Examiner