YONKERS PUBLIC SCHOOLS

Student Health History and Physical Examination

Student's Name: _____ **DOB:** _____ **M F**

Address: _____ **SCHOOL** _____ **GRADE**

Hospitalizations/Surgery: _____

_____

_____

Medications: _____

Ht: _____ **Wt:** _____ **BMI:** _____ **BP:** _____/_____

Vision: R____/____ L____/____ Hearing: _____ **Scoliosis: Yes No**

Allergies: Foods_____ Meds _____
Other _____ Anaphylaxis _____EPI pen Yes No

Asthma: Active Inactive Asthma Action Card® **Diabetes**: Type 1 Type 2 Pump

	WNL	ABNORMAL: comments
Skin		
Skeletal		
HEENT		
Neck		
Lung		
Heart		
Abd/ GI		
GU		
Neuro		

Impression: _____

_____

Full Physical Activity

Restricted Physical Activity

Vaccine	1st	2nd	3rd	4th	5th
DTaP					
Tdap					
OPV/IPV					
MMR					
Hib					
HepB					
HepA					
Varicella					
Meningococcal					
Pneumococcal					
HPV					

PPD:
Date administered:_____
Results: _____ mm
CXR: ____ **Prophylaxis:** ____

Varicella Disease:
Date:_____

STAMP

Physician Signature _____ **Date** _____

Address: _____

Revised 5/2007 / no