STUDENT HEALTH EXAM

Exam to be done by a licensed doctor or nurse practitioner before attending LS and when advancing to grades 3, 6 or 9.

Student's Name: _____ Date of Birth: ____/____/_____ Sex: F / M
Last First Middle *Month/Day/Year* *(circle)*

A. HEALTH HISTORY (including serious injury, illness or surgery): _____

_____

B. CURRENT HEALTH CONCERNS

Yes No ***Please request the relevant form***

☐ ☐ Severe Allergy *If yes, please complete Severe Allergy Care Plan*
History of anaphylaxis to: _____ Auto-injector: ☐ Yes ☐ No

☐ ☐ Asthma or Reactive Airway *If yes, please complete Asthma or Reactive Airway Care Plan*

☐ ☐ Diabetes *If yes, please complete Diabetes Care Plan*

☐ ☐ Seizure disorder *If yes, please complete Epilepsy/Seizure Care Plan*

☐ ☐ Other health condition *Please specify:* _____

C. CURRENT MEDICATIONS (prescription and non-prescription)

Yes No

☐ ☐ *If yes, please complete Authorization for Medication to be Given at School*

D. PHYSICAL EXAM Date of Examination: ____ / ____ / _____ Age: _____ years & _____ months
(mm / dd / yyyy)

Height**:** _____ Weight: _____ BMI: _____ BP: _____ mmHg Pulse: _____ /min

	Normal	Abnormal	Comments
Head, neck	☐	☐	
Eyes (pupils) ENT	☐	☐	
Teeth, gums	☐	☐	
Chest	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Spine (scoliosis), back	☐	☐	
Shoulders, upper extremities	☐	☐	
Hips, lower extremities	☐	☐	
Skin	☐	☐	
Neurological	☐	☐	
Emotional/mental health	☐	☐	
Nutritional status	☐	☐	
Developmental status	☐	☐	

Vision Screening ***(required)***		
Uncorrected	R: 20/___	L: 20/ ___
Corrected	R: 20/___	L: 20/ ___
by wearing	☐ Glasses ☐ Contact lenses	

Hearing Screening ***(required)***				
	500	1000	2000	4000
Right:				
Left:				

Student's Name: _____ Date of Birth: ____/____/_____ Sex: F / M
Last First Middle *Month/Day/Year* *(circle)*

E. TUBERCULOSIS SCREENING

Lincoln School requires students to provide evidence of being free from tuberculosis. Please perform and record the results of the appropriate TB screening test(s) for this child. Contact the school nurse if you have questions regarding which test is required.

BCG vaccine *Not required or recommended* • *If given date must be documented*	Date (mm/dd/yyyy): _____/_____/_____
TB Skin Test (Mantoux, PPD 5 TU) ***REQUIRED*** *if:* • *BCG more than 5 years ago, and/or* • *no history of TB disease or "positive" TB Skin Test*	Date given (mm/dd/yyyy): ____/____/_____ Date read (mm/dd/yyyy): ____/____/_____ Result (in mm induration): _____ mm
TB Interferon Gamma Release Assay (IGRA) ***MAY*** *substitute for TST in those with previous BCG vaccine*	Date (mm/dd/yyyy): _____/_____/_____ Result: _____
Chest X-ray *Required* ***ONLY*** *if:* • *new or prior "positive" TB Skin Test, or* • *history of TB disease, or* • *indicated by current health history or exam*	Date (mm/dd/yyyy): _____/_____/_____ Result:_____
Medical Examination *Required* ***ONLY*** *if:* • *new "positive" TB Skin Test, or* • *abnormal chest x-ray, or* • *BCG less than 5 years ago*	Date (mm/dd/yyyy): _____/_____/_____ Result: _____

F. IMMUNIZATIONS

To attend Lincoln School a student must have age-appropriate immunity against **hepatitis B, diphtheria, tetanus, pertussis, polio, *Haemophilus influenzae* type b, measles, mumps, rubella and varicella.** Additional childhood and travel immunizations are recommended.

Please attach a copy of all immunization records. The Health Office will summarize all vaccines on a single-page Immunization Record.

G. RECOMMENDATIONS

Yes **No** ***Please tick ALL that apply:***

☐ ☐ Approved for participation in age appropriate **physical education and after school activities** *(ALL grades)*

☐ ☐ Approved for participation in age appropriate **competitive sports,** *with Sports Eligibility Health History attached (grades 4-12 ONLY if participating in a competitive sport)*

☐ ☐ Approved for participation in age appropriate **Service Nepal activities** *(grades 6-12 ONLY)*

If no, describe restrictions or precautions _____

_____

_____

Name of examiner: _____ **Signature:** _____

Address: _____ Designation: MD / MBBS / NP *(circle)*

Email: _____ Date: _____ *(mm/dd/yyyy)*

Please attach additional information as needed for the health and safety of the student.