



Annual Health Update

Student Name: _____ Date of Review: _____

Current Health Issues

Problem List: _____

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Please list:
Medications _____
Food _____
Environmental _____
Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Anaphylaxis to _____ Epi-Pen Yes/No |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: Asthma Action Plan Yes No (<i>Please attach</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Impaired glucose tolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder (describe): _____
_____ Diastat: Yes/No |
| <input type="checkbox"/> | <input type="checkbox"/> | Requires SBE prophylaxis for dental or surgical procedures |
| <input type="checkbox"/> | <input type="checkbox"/> | History of problems with anesthesia |
| <input type="checkbox"/> | <input type="checkbox"/> | Has implanted medical device (VNS, cochlear implant, shunt, spinal rod, g-tube, other):
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Requires adaptive equipment: (splints, braces, eye prosthetics, other) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Requires special diet, food textures or fluid consistencies: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (Please specify): _____
_____ |

New Medical Conditions, Surgeries or Changes in the 12 Months (Please describe)

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | New Medical Conditions _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery or Hospitalizations _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in status of a chronic medical condition _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | New medications or changes in medications _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other changes that impact education or activities at school _____
_____ |

This student has issues in the following areas that may impact his/her educational experience:

- Vision Hearing Speech/Language Fine/Gross Motor Deficit
 Emotional/Social Behavior Other _____
 Comments/Recommendations _____

Athletics Participation

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are there restrictions or limitations on participation in athletics or physical activities, if yes, please describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is protective equipment required while participating in athletics or physical activity, if yes, please describe: _____ |

ANNUAL PHYSICAL EXAM

NAME OF STUDENT	DOB	DATE OF EXAM

Height	Weight	BMI	Temp.	B/P	Pulse	Resp.	HGB/HCT	Lead	U/A
in.	lb.	Index	°F						
cm	kg.	%ile	°C						

NOTE: N = In Normal Range X = Abnormality D = Deferred

	N	X	D	Comments
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin, Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head, Hair, Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes, Pupils, Vision, EOMs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Ooscopic Exam, Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nose, Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth, Teeth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck, Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest, Breasts, Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia, Tanner Stage, Testes, Menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities: Pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities: Joints, ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic: Cranial Nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic: Mental Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic: Sensory/Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motor (Gross/Fine), Muscle Tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance, Posture, Spinal Curvatures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Immunizations	Hearing	Vision
<input type="checkbox"/> Up To Date	<input type="checkbox"/> Within Normal Limits for Age	<input type="checkbox"/> Within Normal Limits for Age
<input type="checkbox"/> Scheduled	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Glasses <input type="checkbox"/> Distance <input type="checkbox"/> Near
Include copy of immunization record	<input type="checkbox"/> Other Auditory Aids	<input type="checkbox"/> Lenses <input type="checkbox"/> Contact <input type="checkbox"/> Protective

Physician or Nurse Practitioner Name (**Please Print Clearly**)

Physician or Nurse Practitioner Signature Date

