SEAMAN USD #345 CHILD/YOUTH HEALTH ASSESSMENT
(To be completed by physician/nurse qualified to provide child health assessments)

.

Student Name:_____ DOB: _____ School Name: _____

Please list any medication the student is on at home & medication (dosage & time) and/or procedures that the above named student may need during the school day:

Height: _____ Weight: _____ BMI/%: _____ /_____ Pulse/BP:_____/_____

Vision: _____/_____/_____ Hearing: _____/_____
R L Both R L

With glasses? Yes __ No ___ Contacts? Yes ___ No ___

General Appearance: **Allergies:** _____
(List food, bee sting or medication)

Head: _____ EENT: _____ Abdomen: _____
GU: _____ Dental: _____ CNS: _____
Heart: _____ Skin: _____ Lungs: _____
Musculoskeletal: _____ Nutrition: _____

Any identified developmental delays? ____ yes ____ no
(If yes, please list: _____
_____)

Recommendations:

_____
_____

Immunizations: (Please list by day, month, year.)
*** Indicates mandated by law for school entry**

DPT *	OPV/IPV *	HIB	HEP B *	MMR *	VARICELLA *	OTHER-

_____ _____ _____
Physician/Nurse Name Phone Number Date

_____
Physician/Nurse Signature
Form Revised 2/06 CMT