FAVOR DE ENVIAR UNA COPIA DE LOS REGISTROS DE VACUNAS A LA ENFERMERA DE LA ESCUELA*
**STUDENT'S HEALTH HISTORY** (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes ☐ No ☐

<table>
<thead>
<tr>
<th>Physical exam for grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>K/1 ☐ 6 ☐ 11 ☐ Other ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>NORMAL</th>
<th>*ABNORMAL</th>
<th>DEFER</th>
<th>*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Height: ( ______ ) inches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight: ( ______ ) pounds</td>
</tr>
</tbody>
</table>

BMI: (______)
BMI-for-Age Percentile: (______)%

Pulse: (______)
Blood Pressure: (______ / ____)

Hair/Scalp
Skin
Eyes/Vision Corrected ☐
Ears/Hearing
Nose and Throat
Teeth and Gingiva
Lymph Glands
Heart
Lungs
Abdomen
Genitourinary
Neuromuscular System
Extremities
Spine (Scoliosis)
Other

<table>
<thead>
<tr>
<th>TUBERCULIN TEST</th>
<th>DATE APPLIED</th>
<th>DATE READ</th>
<th>RESULT/FOLLOW-UP</th>
</tr>
</thead>
</table>

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐
Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam ______ 20____
Print name of examiner
Print examiner's office address ______________________________ Phone ______________________________
Signature of examiner ______________________________ MD ☐ DO ☐ PAC ☐ CRNP ☐

*SEND COPY OF IMMUNIZATION RECORD TO SCHOOL NURSE*