Norfolk School Health Examination Card

Last Name _____ First Name _____ Date of Birth _____ Sex _____

Address _____ Phone _____ School _____

Parent's Name (or Guardian) _____

Disease History	Date	Immunizations	1st Date	2nd Date	3rd Date	4th Date	5th Date	6th Date	Significant Medical History
Rheumatic Fever		Polio							
Tuberculosis		DTaP or DT/TD							
Frequent Colds		MMR							
Red Measles		Hepatitis B							
Rubella (3 day measles)		HIB							
Mumps		Varicella							
Chicken Pox		TB							
Allergy									
Seizure Disorder									
Diabetes									
Other									

PARENTS: PLEASE FILL IN THE ABOVE BEFORE TAKING TO M.D.

TEETH AND GUMS

Decayed Deciduous _____ Filled Deciduous _____

Malocclusion

Decayed Permanent _____ Filled Permanent _____

Date of last visit to dentist _____

Recommendations: _____

Dentist _____
Signature

Physical EXAMINATION (cont'd)

Last Name _____ First Name _____

General Appearance _____ Height _____ Weight _____

Nutrition _____ Skin { Clear _____ Eczema _____ Glands _____

Skeletal Development _____

Glands _____

Anemia _____

HEAD	Scalp _____		Right / Left
	Eyes _____	Vision 1. Without Correction _____	_____ _____
	_____	2. With Correction _____	_____ _____
	Ears _____	Hearing _____	_____ _____
	Nose _____	Throat-Tonsils _____	
NECK	Thyroid		
CHEST	Heart _____ Size _____ Rate _____ Rhythm _____ B.P. _____		
	Lungs		
ABDOMEN	Viscera	Hernia	Genitals
Extremities	Upper	Lower	
Neurological	Chorea	Stutter	Nail Biting
URINALYSIS			
RECOMMEN-DATIONS	Physical Activity - Unrestricted _____	Moderate _____	Minimum _____
	Remarks and suggestions _____		
	Date of Exam _____		Signature of Examining Physician