Louisville Public Schools

Health Examination

Name_____________________________________ Birthdate______________ Sex: M_____ F_____
Address ____ Phone _____________ Grade _________
Parent/Guardian Name
____
Name of Health Care Provider
____

The information provided here may be shared with school personnel as needed to promote your child's safety

and educational success. By signing below, the parent/guardian of __________________________________
Name of Student
consents for the release of the health and medical information contained herein to be released to Louisville Public Schools.

____
Signature *Printed name & relationship* *Date*

IMMUNIZATIONS: Please obtain a copy of all immunizations given over the child's lifetime.

Immunizations given during TODAY'S visit:

DTP Polio MMR Varicella Hib
____Other

HEALTH HISTORY:

_______________fainting _______________head injury _______________asthma
_______________seizure _______________surgery _______________allergies
_______________other describe ____
Family history of sudden death prior to age 50 ____

PHYSICAL EXAMINATION:

General appearance _______________ Height _________ Weight __________ BMI __________
Lab: Hct or Hgb. __________ Lead level drawn _____ yes _____ Bp __________
Skeletal development ________________ Posture __________ Scoliosis __________
Head/neck _______________ Hair/skin ___________ Lymph __________ Nose/sinus ___________
Throat ______________ Ears _______________ Mouth ________________ Dental ________________
Speech ________________ Heart ________________ Rhythm __________ Rate __________
Chest/lungs _______________ Abdomen ____
Back __________________ Extremities ____________________ Neurological ___________________
Mental development assessment ____
Is this child subject to conditions limiting classroom or physical activities? ______Yes _______ No
If yes please describe ____

Is this child taking any medications? _________Yes __________No
If yes please list: ____

List concerns/remarks:
____
____
____

HEARING SCREENING: _________ Pass _________ Fail Referral ____________________________

Audio Test	500Hz	1000Hz	2000Hz	4000Hz
Right ear---dBHL				
Left ear---dBHL				

VISION EXAM: (*required for all Kindergarteners and any student transferring from any other state*)

Tests	Pass	Fail	Recommend further examination (*see comments below*)
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
Internal eye health	_____	_____	_____
External eye health	_____	_____	_____

Visual acuity Rt. 20/ _____ Lt. 20/_____ with/without glasses

Comments/recommendations: ____
____
____

_______________ ____ ____________________

Date of exam *Signature of licensed Health Care Provider* *Office phone #*