



Bureau of Community Health Systems  
Division of School Health

## Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

**PARENT / GUARDIAN / STUDENT:**  
Complete page one of this form before  
student's exam. Take completed form to  
appointment.

Student's name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age at time of exam \_\_\_\_\_ Gender:  Male  Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:  
\_\_\_\_\_

Does the student have any allergies?  No  Yes (If yes, list specific allergy and reaction.)

Medicines  Pollens  Food  Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

| GENERAL HEALTH: <i>Has the student...</i>                                                                                                                                                                                                                                                                                     | YES | NO |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Any ongoing medical conditions? If so, please identify:<br><input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection<br>Other _____                                                                                                             |     |    |
| 2. Ever stayed more than one night in the hospital?                                                                                                                                                                                                                                                                           |     |    |
| 3. Ever had surgery?                                                                                                                                                                                                                                                                                                          |     |    |
| 4. Ever had a seizure?                                                                                                                                                                                                                                                                                                        |     |    |
| 5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?                                                                                                                                                                                                        |     |    |
| 6. Ever become ill while exercising in the heat?                                                                                                                                                                                                                                                                              |     |    |
| 7. Had frequent muscle cramps when exercising?                                                                                                                                                                                                                                                                                |     |    |
| HEAD/NECK/SPINE: <i>Has the student...</i>                                                                                                                                                                                                                                                                                    | YES | NO |
| 8. Had headaches with exercise?                                                                                                                                                                                                                                                                                               |     |    |
| 9. Ever had a head injury or concussion?                                                                                                                                                                                                                                                                                      |     |    |
| 10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?                                                                                                                                                                                                                         |     |    |
| 11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?                                                                                                                                                                                                                              |     |    |
| 12. Ever been unable to move arms or legs after being hit or falling?                                                                                                                                                                                                                                                         |     |    |
| 13. Noticed or been told he/she has a curved spine or scoliosis?                                                                                                                                                                                                                                                              |     |    |
| 14. Had any problem with his/her eyes (vision) or had a history of an eye injury?                                                                                                                                                                                                                                             |     |    |
| 15. Been prescribed glasses or contact lenses?                                                                                                                                                                                                                                                                                |     |    |
| HEART/LUNGS: <i>Has the student...</i>                                                                                                                                                                                                                                                                                        | YES | NO |
| 16. Ever used an inhaler or taken asthma medicine?                                                                                                                                                                                                                                                                            |     |    |
| 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply:<br><input type="checkbox"/> Heart murmur or heart infection<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____ |     |    |
| 18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?                                                                                                                                                                                                                                     |     |    |
| 19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded <b>DURING</b> or <b>AFTER</b> exercise?                                                                                                                                                                                                |     |    |
| 20. Had discomfort, pain, tightness or chest pressure during exercise?                                                                                                                                                                                                                                                        |     |    |
| 21. Felt his/her heart race or skip beats during exercise?                                                                                                                                                                                                                                                                    |     |    |
| BONE/JOINT: <i>Has the student...</i>                                                                                                                                                                                                                                                                                         | YES | NO |
| 22. Had a broken or fractured bone, stress fracture, or dislocated joint?                                                                                                                                                                                                                                                     |     |    |
| 23. Had an injury to a muscle, ligament, or tendon?                                                                                                                                                                                                                                                                           |     |    |
| 24. Had an injury that required a brace, cast, crutches, or orthotics?                                                                                                                                                                                                                                                        |     |    |
| 25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?                                                                                                                                                                                                                                        |     |    |
| 26. Had joints that become painful, swollen, feel warm, or look red?                                                                                                                                                                                                                                                          |     |    |
| SKIN: <i>Has the student...</i>                                                                                                                                                                                                                                                                                               | YES | NO |
| 27. Had any rashes, pressure sores, or other skin problems?                                                                                                                                                                                                                                                                   |     |    |
| 28. Ever had herpes or a MRSA skin infection?                                                                                                                                                                                                                                                                                 |     |    |

| GENITOURINARY: <i>Has the student...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                              | YES | NO |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 29. Had groin pain or a painful bulge or hernia in the groin area?                                                                                                                                                                                                                                                                                                                                                                                                                    |     |    |
| 30. Had a history of urinary tract infections or bedwetting?                                                                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| 31. <b>FEMALES ONLY:</b> Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes: At what age was her first menstrual period? _____<br>How many periods has she had in the last 12 months? _____<br>Date of last period: _____                                                                                                                                                                                                                     |     |    |
| DENTAL:                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES | NO |
| 32. Has the student had any pain or problems with his/her gums or teeth?                                                                                                                                                                                                                                                                                                                                                                                                              |     |    |
| 33. Name of student's dentist: _____<br>Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years                                                                                                                                                                                                                                                                                                 |     |    |
| SOCIAL/LEARNING: <i>Has the student...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                            | YES | NO |
| 34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?                                                                                                                                                                                                                                                                                                                                                            |     |    |
| 35. Been bullied or experienced bullying behavior?                                                                                                                                                                                                                                                                                                                                                                                                                                    |     |    |
| 36. Experienced major grief, trauma, or other significant life event?                                                                                                                                                                                                                                                                                                                                                                                                                 |     |    |
| 37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?                                                                                                                                                                                                                                                                                                                                             |     |    |
| 38. Been worried, sad, upset, or angry much of the time?                                                                                                                                                                                                                                                                                                                                                                                                                              |     |    |
| 39. Shown a general loss of energy, motivation, interest or enthusiasm?                                                                                                                                                                                                                                                                                                                                                                                                               |     |    |
| 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?                                                                                                                                                                                                                                                                                                                                                                |     |    |
| 41. Used (or currently uses) tobacco, alcohol, or drugs?                                                                                                                                                                                                                                                                                                                                                                                                                              |     |    |
| FAMILY HEALTH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | YES | NO |
| 42. Is there a family history of the following? If so, check all that apply:<br><input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome<br><input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems<br><input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease<br>Other _____ |     |    |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply:<br><input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome<br><input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____                   |     |    |
| 44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?                                                                                                                                                                                                                                                                                                                                                                             |     |    |
| 45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?                                                                                                                                                                                                                                                                 |     |    |
| QUESTIONS OR CONCERNS                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | YES | NO |
| 46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)                                                                                                                                                                                                                                                                                                        |     |    |

**I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.**

Signature of parent / guardian / emancipated student \_\_\_\_\_ Date \_\_\_\_\_

| STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes <input type="checkbox"/> No <input type="checkbox"/>  |           |           |       |                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------|-------|--------------------------------------------------|
| Physical exam for grade:<br><br>K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/> | CHECK ONE |           |       | *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS |
|                                                                                                                                                    | NORMAL    | *ABNORMAL | DEFER |                                                  |
| Height: (            ) inches                                                                                                                      |           |           |       |                                                  |
| Weight: (            ) pounds                                                                                                                      |           |           |       |                                                  |
| BMI: (            )                                                                                                                                |           |           |       |                                                  |
| BMI-for-Age Percentile: (            )%                                                                                                            |           |           |       |                                                  |
| Pulse: (            )                                                                                                                              |           |           |       |                                                  |
| Blood Pressure: (    /    )                                                                                                                        |           |           |       |                                                  |
| Hair/Scalp                                                                                                                                         |           |           |       |                                                  |
| Skin                                                                                                                                               |           |           |       |                                                  |
| Eyes/Vision          Corrected <input type="checkbox"/>                                                                                            |           |           |       |                                                  |
| Ears/Hearing                                                                                                                                       |           |           |       |                                                  |
| Nose and Throat                                                                                                                                    |           |           |       |                                                  |
| Teeth and Gingiva                                                                                                                                  |           |           |       |                                                  |
| Lymph Glands                                                                                                                                       |           |           |       |                                                  |
| Heart                                                                                                                                              |           |           |       |                                                  |
| Lungs                                                                                                                                              |           |           |       |                                                  |
| Abdomen                                                                                                                                            |           |           |       |                                                  |
| Genitourinary                                                                                                                                      |           |           |       |                                                  |
| Neuromuscular System                                                                                                                               |           |           |       |                                                  |
| Extremities                                                                                                                                        |           |           |       |                                                  |
| Spine (Scoliosis)                                                                                                                                  |           |           |       |                                                  |
| Other                                                                                                                                              |           |           |       |                                                  |

| TUBERCULIN TEST | DATE APPLIED | DATE READ | RESULT/FOLLOW-UP |
|-----------------|--------------|-----------|------------------|
|                 |              |           |                  |
|                 |              |           |                  |

| 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 <input type="checkbox"/> No <input type="checkbox"/>                                                          |
| Physical exam performed at: Personal Health Care Provider's Office <input type="checkbox"/> School <input type="checkbox"/> Date of exam _____ 20_____ |
| Print name of examiner _____                                                                                                                           |
| Print examiner's office address _____ Phone _____                                                                                                      |
| Signature of examiner _____ MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/>         |

**HEALTH CARE PROVIDERS:** *Please photocopy immunization history from student's record – OR – insert information below.*

**IMMUNIZATION EXEMPTION(S):**

Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_  
 Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_  
 Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

| VACCINE                                                                                 | DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization |    |    |    |    |
|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----|----|----|----|
| Diphtheria/Tetanus/Pertussis (child)<br>Type: DTaP, DTP or DT                           | 1                                                                              | 2  | 3  | 4  | 5  |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td                     | 1                                                                              | 2  | 3  | 4  | 5  |
| Polio<br>Type: OPV or IPV                                                               | 1                                                                              | 2  | 3  | 4  | 5  |
| Hepatitis B (HepB)                                                                      | 1                                                                              | 2  | 3  | 4  | 5  |
| Measles/Mumps/Rubella (MMR)                                                             | 1                                                                              | 2  | 3  | 4  | 5  |
| Mumps disease diagnosed by physician <input type="checkbox"/>                           | Date: _____                                                                    |    |    |    |    |
| Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>            | 1                                                                              | 2  | 3  | 4  | 5  |
| Serology: (Identify Antigen/Date/POS or NEG)<br>i.e. Hep B, Measles, Rubella, Varicella | 1                                                                              | 2  | 3  | 4  | 5  |
| Meningococcal Conjugate Vaccine (MCV4)                                                  | 1                                                                              | 2  | 3  | 4  | 5  |
| Human Papilloma Virus (HPV)<br>Type: HPV2 or HPV4                                       | 1                                                                              | 2  | 3  | 4  | 5  |
| Influenza<br>Type: TIV (injected)<br>LAIV (nasal)                                       | 1                                                                              | 2  | 3  | 4  | 5  |
|                                                                                         | 6                                                                              | 7  | 8  | 9  | 10 |
|                                                                                         | 11                                                                             | 12 | 13 | 14 | 15 |
| Haemophilus Influenzae Type b (Hib)                                                     | 1                                                                              | 2  | 3  | 4  | 5  |
| Pneumococcal Conjugate Vaccine (PCV)<br>Type: 7 or 13                                   | 1                                                                              | 2  | 3  | 4  | 5  |
| Hepatitis A (HepA)                                                                      | 1                                                                              | 2  | 3  | 4  | 5  |
| Rotavirus                                                                               | 1                                                                              | 2  | 3  | 4  | 5  |
| <b>Other Vaccines: (Type and Date)</b>                                                  |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |





学龄学生的  
私人机构或学校体检

家长/监护人/学生:

学生体检前, 应先完成本表第 1 页的填写。

把填写好的表格交给预约就诊处。

社区卫生系统局 学校卫生处

学生姓名 \_\_\_\_\_ 日期 \_\_\_\_\_  
 出生日期 \_\_\_\_\_ 体检时的年龄 \_\_\_\_\_ 性别:  男  女

**药物和过敏:** 请列出学生目前正在服用的所有处方药、非处方药及补充剂 (草药/营养品):

学生是否有任何过敏反应? 没有 有 (如有, 请列出具体的过敏物和过敏反应。)

药物  花粉  食物  叮咬昆虫

填写以下部分, 用“√”在“是”或“否”栏中进行标记; 对于不确定答案的问题, 用圆圈标记。

| 综合健康状况: 学生是否.....                                                                                                                                                                                              | 是 | 否 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 1. 有仍在持续的病症? 如有, 请标出:<br><input type="checkbox"/> 哮喘 <input type="checkbox"/> 贫血 <input type="checkbox"/> 糖尿病 <input type="checkbox"/> 感染<br>其他 _____                                                          |   |   |
| 2. 曾有留院超过一晚的情况?                                                                                                                                                                                                |   |   |
| 3. 曾做过手术?                                                                                                                                                                                                      |   |   |
| 4. 曾有过癫痫发作?                                                                                                                                                                                                    |   |   |
| 5. 曾有出生时没有或缺失肾脏、眼睛、睾丸 (男性)、脾脏或任何其他器官的病史?                                                                                                                                                                       |   |   |
| 6. 曾在高温下锻炼时生病?                                                                                                                                                                                                 |   |   |
| 7. 锻炼时经常出现肌肉痉挛?                                                                                                                                                                                                |   |   |
| 头部/颈部/脊柱: 学生是否.....                                                                                                                                                                                            | 是 | 否 |
| 8. 锻炼时出现过头痛?                                                                                                                                                                                                   |   |   |
| 9. 曾有过头部受伤或脑震荡?                                                                                                                                                                                                |   |   |
| 10. 曾有过头部撞击或打击, 并造成过头脑混乱、长期头痛或记忆问题?                                                                                                                                                                            |   |   |
| 11. 曾在撞击或跌倒后, 手臂或腿部出现过麻木、刺痛或无力感?                                                                                                                                                                               |   |   |
| 12. 曾在撞击或跌倒后, 有过无法移动手臂或腿的情况?                                                                                                                                                                                   |   |   |
| 13. 曾注意到或被告知有脊柱弯曲或脊柱侧弯?                                                                                                                                                                                        |   |   |
| 14. 眼睛 (视力) 出现过任何问题, 或有过眼外伤史?                                                                                                                                                                                  |   |   |
| 15. 戴过处方眼镜或隐形眼镜?                                                                                                                                                                                               |   |   |
| 心脏/肺部: 学生是否.....                                                                                                                                                                                               | 是 | 否 |
| 16. 曾使用过吸入器或服用过哮喘药物?                                                                                                                                                                                           |   |   |
| 17. 医生是否说过该男孩 (或女孩) 有心脏病? 如果是, 请勾选所有适用项:<br><input type="checkbox"/> 心脏杂音或心脏感染<br><input type="checkbox"/> 高血压 <input type="checkbox"/> 川崎病<br><input type="checkbox"/> 高胆固醇 <input type="checkbox"/> 其他 _____ |   |   |
| 18. 医生是否要求过该男孩 (或女孩) 做心脏检查? (如心电图 (ECG/EKG)、超声心动图)?                                                                                                                                                            |   |   |
| 19. 运动期间或运动后, 是否有过咳嗽、喘息、呼吸困难、呼吸急促或头晕的情况?                                                                                                                                                                       |   |   |
| 20. 运动期间是否有过不适、疼痛、胸闷或胸压的情况?                                                                                                                                                                                    |   |   |
| 21. 运动过程中能感觉到该男孩 (或女孩) 心跳加速或漏跳?                                                                                                                                                                                |   |   |
| 骨骼/关节: 学生是否.....                                                                                                                                                                                               | 是 | 否 |
| 22. 曾有过骨折或骨裂、应力性骨折或关节脱位?                                                                                                                                                                                       |   |   |
| 23. 曾有过肌肉、韧带或肌腱受伤?                                                                                                                                                                                             |   |   |
| 24. 曾受伤并需要支架、石膏、拐杖或矫形器的情况?                                                                                                                                                                                     |   |   |
| 25. 曾在受伤后需要拍 x 光片、MRI、CT 扫描、注射或物理治疗?                                                                                                                                                                           |   |   |
| 26. 曾有关节疼痛、肿胀、发热或发红的情况?                                                                                                                                                                                        |   |   |
| 皮肤: 学生是否.....                                                                                                                                                                                                  | 是 | 否 |
| 27. 曾有过皮疹、褥疮或其他皮肤问题?                                                                                                                                                                                           |   |   |
| 28. 曾有过疱疹或 MRSA 皮肤感染?                                                                                                                                                                                          |   |   |

| 泌尿生殖系统: 学生是否.....                                                                                                                                                                                                                                                                                                    | 是 | 否 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 29. 曾有过腹股沟疼痛或腹股沟区域出现疼痛的隆起或疝?                                                                                                                                                                                                                                                                                         |   |   |
| 30. 曾有尿路感染或尿床史?                                                                                                                                                                                                                                                                                                      |   |   |
| 31. 仅限女生: 是否已来月经? <input type="checkbox"/> 是 <input type="checkbox"/> 否<br>如为“是”: 该女生第一次来月经的年龄是多大? _____<br>过去的 12 个月, 该女生一共来过多少次月经? _____<br>上次月经的日期: _____                                                                                                                                                         |   |   |
| 牙科:                                                                                                                                                                                                                                                                                                                  | 是 | 否 |
| 32. 学生的牙龈或牙齿是否有过疼痛或问题?                                                                                                                                                                                                                                                                                               |   |   |
| 33. 学生牙医的姓名: _____<br>上次牙科检查的时间: <input type="checkbox"/> 不到 1 年 <input type="checkbox"/> 1-2 年 <input type="checkbox"/> 超过 2 年                                                                                                                                                                                      |   |   |
| 社交/学习: 学生是否.....                                                                                                                                                                                                                                                                                                     | 是 | 否 |
| 34. 曾被告告知有学习障碍、智力或发育障碍、认知延迟、ADD/ADHD 等问题?                                                                                                                                                                                                                                                                            |   |   |
| 35. 曾被霸凌或经历过霸凌行为?                                                                                                                                                                                                                                                                                                    |   |   |
| 36. 经历过重大悲伤、创伤或其他重大的生活事件?                                                                                                                                                                                                                                                                                            |   |   |
| 37. 曾表现出行为、社交关系、成绩、饮食或睡眠习惯的显著变化; 远离家人或朋友的情况?                                                                                                                                                                                                                                                                         |   |   |
| 38. 大多数时候会感到担心、悲伤、沮丧或愤怒?                                                                                                                                                                                                                                                                                             |   |   |
| 39. 表现出精力、动力、兴趣或热情的普遍丧失?                                                                                                                                                                                                                                                                                             |   |   |
| 40. 对体重有顾虑; 一直在尝试增重或减肥, 或曾收到过增重或减肥的建议?                                                                                                                                                                                                                                                                               |   |   |
| 41. 曾使用过 (或目前正在使用) 烟草、酒精或药物?                                                                                                                                                                                                                                                                                         |   |   |
| 家族健康状况:                                                                                                                                                                                                                                                                                                              | 是 | 否 |
| 42. 是否有以下家族病史? 如果是, 请勾选所有适用项:<br><input type="checkbox"/> 贫血/血液病 <input type="checkbox"/> 遗传性疾病/综合征<br><input type="checkbox"/> 哮喘/肺部问题 <input type="checkbox"/> 肾脏问题<br><input type="checkbox"/> 行为健康问题 <input type="checkbox"/> 癫痫病<br><input type="checkbox"/> 糖尿病 <input type="checkbox"/> 镰状细胞特征或疾病<br>其他 _____ |   |   |
| 43. 是否有以下心脏相关问题的家族病史? 如果是, 请勾选所有适用项:<br><input type="checkbox"/> 布鲁鲁达综合征 <input type="checkbox"/> QT 综合征<br><input type="checkbox"/> 心脏病 <input type="checkbox"/> 马凡氏综合征<br><input type="checkbox"/> 高血压 <input type="checkbox"/> 室性心动过速<br><input type="checkbox"/> 高胆固醇 其他 _____                                   |   |   |
| 44. 是否有任何家庭成员出现过不明原因的晕厥、癫痫发作或差点淹死?                                                                                                                                                                                                                                                                                   |   |   |
| 45. 是否有任何家庭成员/亲属在 50 岁之前死于心脏病或在 50 岁之前意外/不明原因的猝死 (包括溺水、不明原因的车祸、婴儿猝死综合症)?                                                                                                                                                                                                                                             |   |   |
| 问题或关切                                                                                                                                                                                                                                                                                                                | 是 | 否 |
| 46. 学生、家长或监护人是否有任何问题或关切想与医疗保健提供方讨论? (如有, 请在本表第 4 页填写。)                                                                                                                                                                                                                                                               |   |   |

特此证明, 本人已尽我所知, 确保所有信息的真实与完整。同意学校护士与医疗保健提供方之间进行健康信息的交换。

家长/监护人/独立的学生签字: \_\_\_\_\_ 日期 \_\_\_\_\_

开始检查前, 已查阅学生的健康史 (本表的第 1 页): 是  否

| 体检年级:<br>K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/><br>其他 <input type="checkbox"/> | 选择其一 |      |      | *异常发现/建议/转诊 |
|-----------------------------------------------------------------------------------------------------------------------------|------|------|------|-------------|
|                                                                                                                             | 正常   | *不正常 | 延期检查 |             |
| 身高: ( ) 英寸                                                                                                                  |      |      |      |             |
| 体重: ( ) 磅                                                                                                                   |      |      |      |             |
| BMI: ( )                                                                                                                    |      |      |      |             |
| BMI 的同龄百分位数: ( ) %                                                                                                          |      |      |      |             |
| 脉搏: ( )                                                                                                                     |      |      |      |             |
| 血压: ( / )                                                                                                                   |      |      |      |             |
| 头发/头皮                                                                                                                       |      |      |      |             |
| 皮肤                                                                                                                          |      |      |      |             |
| 眼镜/视力 已矫正 <input type="checkbox"/>                                                                                          |      |      |      |             |
| 耳部/听力                                                                                                                       |      |      |      |             |
| 鼻、喉                                                                                                                         |      |      |      |             |
| 牙齿和牙龈                                                                                                                       |      |      |      |             |
| 淋巴腺                                                                                                                         |      |      |      |             |
| 心脏                                                                                                                          |      |      |      |             |
| 肺部                                                                                                                          |      |      |      |             |
| 腹部                                                                                                                          |      |      |      |             |
| 泌尿生殖系统                                                                                                                      |      |      |      |             |
| 神经肌肉系统                                                                                                                      |      |      |      |             |
| 四肢                                                                                                                          |      |      |      |             |
| 脊柱 (脊柱侧弯)                                                                                                                   |      |      |      |             |
| 其他                                                                                                                          |      |      |      |             |

| 结核菌素试验 | 申请日期 | 读取日期 | 结果/后续 |
|--------|------|------|-------|
|        |      |      |       |
|        |      |      |       |

需接受药物治疗、限制活动或可能给教育带来影响的身体状况或慢性病  
(更多备注可填写在第 4 页)

体检时, 家长/监护人是否在场: 是  否

体检地点: 个人医疗保健提供方的办公室  学校

检查日期: \_\_\_\_\_ 20\_\_\_\_

检查人员的打印姓名: \_\_\_\_\_

检查人员的打印办公地址: \_\_\_\_\_ 电话: \_\_\_\_\_

检查人员的签名: \_\_\_\_\_ MD  DO  PAC  CRNP

医疗保健提供方：请复印学生记录中的免疫接种史，或在下方填入信息。

**免疫接种豁免：**

医疗  批准日期：\_\_\_\_\_ 原因：\_\_\_\_\_ 撤销日期：\_\_\_\_\_

医疗  批准日期：\_\_\_\_\_ 原因：\_\_\_\_\_ 撤销日期：\_\_\_\_\_

医疗  批准日期：\_\_\_\_\_ 原因：\_\_\_\_\_ 撤销日期：\_\_\_\_\_

**注意：**对于宗教或哲学原因的接种豁免，家长/监护人必须向学校提出书面申请。

| 疫苗                                                           | 文件：(1) 疫苗类型；(2) 每次免疫接种的日期 (年/月/日) |    |    |    |    |
|--------------------------------------------------------------|-----------------------------------|----|----|----|----|
| 白喉/破伤风/百日咳 (儿童) 类<br>型：DTaP、DTP 或 DT                         | 1                                 | 2  | 3  | 4  | 5  |
| 白喉/破伤风/百日咳 (青少年/成人)<br>类型：Tdap 或 Td                          | 1                                 | 2  | 3  | 4  | 5  |
| 脊髓灰质炎<br>类型：OPV 或 IPV                                        | 1                                 | 2  | 3  | 4  | 5  |
| 乙型肝炎 (HepB)                                                  | 1                                 | 2  | 3  | 4  | 5  |
| 麻疹/腮腺炎/风疹 (MMR)                                              | 1                                 | 2  | 3  | 4  | 5  |
| 经医生诊断的腮腺炎 <input type="checkbox"/>                           | 日期：_____                          |    |    |    |    |
| 水痘：疫苗 <input type="checkbox"/> 出过水痘 <input type="checkbox"/> | 1                                 | 2  | 3  | 4  | 5  |
| 血清学检查：(识别抗原/日期/阳性或阴性)<br>如乙型肝炎、麻疹、风疹、水痘                      | 1                                 | 2  | 3  | 4  | 5  |
| 脑膜炎球菌结合疫苗 (MCV4)                                             | 1                                 | 2  | 3  | 4  | 5  |
| 人乳头瘤病毒 (HPV) 类型：<br>HPV2 或 HPV4                              | 1                                 | 2  | 3  | 4  | 5  |
| 流感病毒<br>类型：TIV (注射)<br>LAIV (鼻腔喷雾)                           | 1                                 | 2  | 3  | 4  | 5  |
|                                                              | 6                                 | 7  | 8  | 9  | 10 |
|                                                              | 11                                | 12 | 13 | 14 | 15 |
| B 型流感嗜血杆菌 (Hib)                                              | 1                                 | 2  | 3  | 4  | 5  |
| 肺炎球菌结合疫苗 (PCV) 类型：7 或<br>13                                  | 1                                 | 2  | 3  | 4  | 5  |
| 甲型肝炎 (HepA)                                                  | 1                                 | 2  | 3  | 4  | 5  |
| 轮状病毒                                                         | 1                                 | 2  | 3  | 4  | 5  |
| <b>其他疫苗：(类型和日期)</b>                                          |                                   |    |    |    |    |
|                                                              |                                   |    |    |    |    |
|                                                              |                                   |    |    |    |    |
|                                                              |                                   |    |    |    |    |
|                                                              |                                   |    |    |    |    |

