To be completed by the Physician:

LOVELAND CITY SCHOOL DISTRICT HEALTH HISTORY

Child's Name _____ Date _____

Child's Date of Birth _____ Male _____ Female _____

Objective Data:

Height _____ Weight _____ BMI_____ B.P. _____/_____

IMMUNIZATION RECORD

TYPE	DATE(S)					
DTaP						
TD						
IPV						
MMR						
HEPATITIS B						
VARICELLA						
MUMPS						
HIB-d						
OTHER						

Required compulsory immunization law (for entering school): 5 DTaP, 4 IPV, 2 MMR, 3 Hepatitis B and 2 Varicella. A TB Screen is required for all students who have lived **in the United States for less than one year.** Test must be within 90 days of starting school or within two weeks after.

SCREENING TESTS

Vision: Date done _____

Distance Acuity R _____ L _____

Stereopsis (3D) Pass _____ Fail _____ Not done _____

Farsightedness Pass _____ Fail _____ Not done _____

Color Pass _____ Fail _____ Not done _____

Child wear glasses? Yes _____ No _____

Tested with glasses? Yes _____ No _____

Referral Made? Yes _____ No _____

Hearing: Date done _____

Audiometric thresholds:

R-ear Pass _____ Fail _____ Not done _____

L-ear Pass _____ Fail _____ Not done _____

Other test (specify) _____

_____

Child wears a hearing aid? Yes _____ No _____

Tested with hearing aid? Yes _____ No _____

Referral Made? Yes _____ No _____

SPEECH/LANGUAGE

Speech assessment: Done _____ Not done _____ Child has no discernible speech problem _____

Child has possible problem with disorders: (check) Articulation _____ Rhythm _____ Voice _____ Language _____

Speech evaluation recommended: Yes _____ No _____

LABORATORY TESTS

Hematocrit/Hemoglobin _____ Urine Protein _____ Urine blood _____

Urine Glucose _____ Other _____

(CONTINUED ON THE OTHER SIDE)

PHYSICAL EXAMINATION

Date examined _____ Essentially normal _____ Abnormalities as follows:

_____
_____
_____
_____

If this child has any physical, developmental, or behavioral problems, how can the school assist with special programs, placement, or attention?

_____
_____
_____
_____

Is this child able to participate fully in the following:

A. Classroom and academic activities: Yes _____ No _____
B. Physical education classes? Yes _____ No _____
C. Competitive athletics? Yes _____ No _____
D. Contact and collision sports? Yes _____ No _____

If limitations are advised, please specify those limitations:

_____
_____
_____
_____

PHYSICIANS ASSESSMENT

Problem list	Recommendation for school management
1.	**1.**
2.	**2.**
3.	**3.**

Please print or stamp:

Physician's Name _____
Address _____
Phone _____

_____
Physicians Signature

_____
Date signed