Parkersburg Academy HEALTH APPRAISAL

_	Parent	\circ	٠.

Parent's signature

The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested in Section I. Section II may be certified by transcription of information from the certificate of immunization. The remaining sections (III, IV, V) are to be completed by a doctor, purse, and dentist. (BE SURE TO BRING YOU CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)

RSONAL ld's Name			Middle	Sex		Date of Birth
Last First dress			Middle			Today's Date
Number & Street			City	Zip		·
ent's or Guardian's Name			First	Middle		Telephone (Home)
			FIRST	Middle		T 1 1 (W 1)
lress Number & Street			City	Zip		Telephone (Work)
your child having any of the problems listed below? 1. Allergies of reactions: (For example, food,	YES	NO		ch as "UP TO DAT school may be denie	ed on the basis of t	E" will not be accepte his information ADMINISTERED
medication, or other)			OTP/OT/Td		Mo/Day/Yr:	Mo/Day/Yr:
2. Hay fever, asthma, or wheezing		\perp	(Specify Typ	Type		
Eczema or frequent skin rashes			(Specify Typ		1.	6.
4. Convulsion/Seizures					2.	7.
5. Heart trouble		+			3.	8.
6. Diabetes	_	++			4.	9.
7. Frequent colds, sore throats, earaches (4 or more per year)			2.11		5.	10.
8. Trouble with passing urine or bowel movements		+	Polio		1.	4.
9. Shortness of breath		+	(Specify Typ OPV/IPV		2.	5.
10. Speech problems		+	OF V/IF V		3.	
11. Menstrual problems		+	Haemophilus		1.	3.
12. Dental problems. Date of last examination			Influenza typ		2.	<u> </u>
13. Other						given before 12 mont
				sage must be repeate		given before 12 mon
ease explain any problem areas identified above:	<u> </u>	'	MMR	sage must be repeat	1	
			Hepatitis B		1.	3.
					2.	
			OTHER VAC	CCINES		
				ician diagnosis of oratory evidence of applicable		
Ooes your child take any medication regularly?			REACTIONS/CO	VACCINES WAVED DUE TO REACTIONS/CONTRADICATIONS/ RELIGIOUS OBJECTIONS I certify that the immunization date		

SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS EXAMINATION AND/OR INSPECTIONS

ESSENTIAL FINDINGS	DEVIATING FROM N	ORMAL AN	D/OR REG	COMMEND	ATIONS				
			TECT	C AND ME	CLIDEMENTO				
		N1			ASUREMENTS		N1	111	D -f1
(r) :		Normal	Under Care	Referred	V. 1 . 5 . 0		Normal	Under Care	Referred
Vision Tested? ☐ Yes ☐ No Date	☐ Visual Acuity ☐ Ocular Muscle ☐ Other				Urinalysis Done? ☐ Yes ☐ No Date	Sugar Albumin Microscopic			
Hearing Tested? ☐ Yes ☐ No	☐ Audiometer ☐ Other				Blood Pressure Mea Yes No Reading				
Hemoglobin/Hemotocrit Tested? Yes No					Height Weight Other:				
ESSENTIAL FINDING D	EVIATING FROM NO	RMAL AND	OR REC	OMMENDA	ATIONS —				
DOCTOR'S/NURSE'S SI	GNATURE				DATE:				
Tuberculin Test (if given)	Date	Type:	:		Negative	Positive		mn	n.
SECTION IV- RECOMP	MENDATIONS								
Is there any defect of visio If yes, please explain:	n, hearing, or other cond	ditions for wh	ich the scl	hool could h	elp by seating or othe	r action? Yes	s 🔲 i	No	
Should the student's activi Classroom Playgr	ty be restricted because round Gymnasium	of any physic	cal defect of ing Pool	or illness? Y	es	yes, check below annp	d explain d	legree of 1	restriction:
Examiner's Signature	Date	Examiner's Name (print or type)			Degree or License				
Number & Street	City	Zip Telephone							
SECTION V – DENTAL	EXAMINATION AN	D RECOMM	IENDATI	IONS (OPT	IONAL)				
I have examined	Child's Name teeth a	and make the	following	recommenda	ations as to treatment:	:			
		Dentist's Signature			Date				
COMMENTS:									