ACA SCHOOL HEALTH REPORT

Section I – To be completed by parent/ guardian

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ HOME PHONE: _____

_____

PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

_____

DENTIST: _____ PHONE: _____

ADDRESS: _____

_____

Is your child having any of the problems listed below?	Yes	No
1. Allergies or reactions: (For example, food, medication, or other		
2. Hay fever, asthma, or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsion/ Seizures		
5. Heart trouble		
6. Diabetes		
7. Frequent colds, sore throat, earaches (4 or more per year)		
8. Trouble with passing urine or bowl movements		
9. Shortness of breath		
10. Speech problem		

Please explain any problem areas identified above:

_____

_____

_____

Does your child take any medication regularly? Yes ☐ No ☐

If yes, what medication? _____

Reason for medication? _____

Parent / Guardian Signature _____

SECTION II – To be filled out by Physician

IMMUNIZATION RECORD

TYPE	DATE	DATE	DATE	DATE	DATE	DATE
DPT						
TD						
POLIO						
MMR						
HIB						
Hepatitis B						
Varicella						
Other						
Other						

Please list and describe any allergies to medications, food, or environment

_____

_____

_____

Has child been prescribed Epipen _____

Inhaler _____

Vision Tested? ☐ Visual Acuity YES NO ☐ Ocular Muscles ☐ ☐ ☐ Other Date _____	Normal	Under care	Referred	Urinalysis Done? ☐ Sugar YES NO ☐ Albumin ☐ ☐ ☐ Microscopic Date _____	Normal	Under care	Referred
Hearing Test? YES NO ☐ Audiometer ☐ ☐ ☐ Other Date_____							
Hemoglobin/ Hemotocrit Tested? YES NO ☐ ☐							

PHYSICAL ASSESSMENT

PLEASE CHECK ONE:

☐ Entirely within normal limits

☐ Abnormalities as follows:

Is there any reason why the student cannot carry out full program of school work? Yes ☐ No ☐

If yes, what is the reason?

Doctor's Signature_____ Date_____

SECTION III To be filled out by Dentist

DENTIST'S REPORT

The following statements are applicable: (Please check)

_____ All necessary services have been performed

_____ No restorative services are required at this time

_____ Further treatment is indicated

_____ Further appointments have been arranged

Dentist's Signature _____