WAPSIE VALLEY PUPIL HEALTH RECORD

* Must be signed by a physician.

NAME Last First Middle	ADDRESS	PHONE	D.O.B.	MALE / FEMALE

Parent or Guardian	PHONE	FAMILY DOCTOR	ADDRESS	NOTIFY IN AN EMERGENCY	PHONE

Medication Taken Regularly	Allergies	Conditions that may effect school performance

HISTORY				DATES						TESTS			
DISEASES	DATE	OPERATIONS ACCIDENTS	DATE	IMMUNIZATION	ORIGINAL 1	ORIGINAL 2	ORIGINAL 3	BOOSTER 4	BOOSTER 5	TEST	DATE	POS.	NEG.
CHICKEN POX				D.P.T.									
Rubella-Germ.Measles				D.T.									
HEPATITIS				TETANUS									
MEASLES-RUBEOLA				POLIOMYELITIS									
MUMPS				RUBELLA									
PNEUMONIA				RUBEOLA- MEASLES									
RHEUMATIC FEVER				MUMPS									
ASTHMA				M.M.R.									
OTHER				H.I.B.									

PHYSICAL EXAMINATIONS

	DATE:	DATE:	DATE:	DATE :	DATE:
HEIGHT & WEIGHT					
POSTURE					
NUTRITION					
SKIN					
FEET					
NOSE & THROAT					
EYES & EARS					
TONSILS & GLANDS					
HEART & LUNGS					
ABDOMEN					
GENITALS					
URINALYSIS					
BLOOD COUNT					
BLOOD PRESSURE					
* EXAMINING PHYSICIAN					

DATE	DESCRIPTION OF ABNORMALITIES OR HANDICAPS, SPECIFIC RECOMMENDATIONS AND COMMENTS