

STUDENT HEALTH REVIEW/EXAM

SECTION A: To be completed by parent or guardian.

Student Last Name <input style="width:90%;" type="text"/>	Student First Name <input style="width:90%;" type="text"/>	MI <input style="width:20px; height:20px;" type="text"/>	Date of birth <input style="width:90%; border-bottom: 1px solid black;" type="text"/>	Grade <input style="width:80%; height:20px;" type="text"/>
Address <input style="width:95%; height:30px;" type="text"/>		City <input style="width:80%; height:25px;" type="text"/>	Zipcode <input style="width:80%; height:25px;" type="text"/>	
Phone <input style="width:95%; height:30px;" type="text"/>	Emergency Phone <input style="width:95%; height:30px;" type="text"/>	Date of last physical exam <input style="width:95%; border-bottom: 1px solid black;" type="text"/>		
Are your immunizations up to <input type="checkbox"/> Yes <input type="checkbox"/> No	Last tetanus shot <input style="width:40%; border-bottom: 1px solid black;" type="text"/>	Last measles shot <input style="width:40%; border-bottom: 1px solid black;" type="text"/>	Last TB skin test <input style="width:40%; border-bottom: 1px solid black;" type="text"/>	

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been told that you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had racing of your heart or skipped beats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have any skin problems (<i>itching, rashes, acne</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a concussion? If yes, how many _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you suffer from migraines? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you use any medical assistant devices (<i>insulin pump, prosthetic, implanted device, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest | | |
| ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand | | |
| 26. Have you ever had other medical problems (<i>infectious mononucleosis, diabetes, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you had any medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Are you Diabetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Are you Asthmatic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have any allergies (<i>medicine, bees or other stinging insects</i>)?? | <input type="checkbox"/> | <input type="checkbox"/> |
| List all allergies: _____ | | |
| 31. When was your first menstrual period? _____ | | |
| When was your last menstrual period? _____ | | |
| What was the longest time between your periods last year? _____ | | |
| 32. Explain all "yes" answers: _____ | | |
| _____ | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH REVIEW/EXAM

SECTION B: To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic

This form to be sent to the school (do not send to ASAA)

Student Last Name
Student First Name
MI
Date of birth
Grade

Height
Weight
Blood Pressure
Pulse

Vision — Right Eye
Vision — Left Eye
Vision Corrected? Yes No
 Pupils

	NORMAL	ABNORMAL FINDINGS	
INITIALS			
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			

Clearance: Cleared
 Cleared with restriction: _____
 Not cleared. Explain why: _____

Name of M.D., D.O. P.A., ANP, CHAP or DC (circled)
Signature
Date

Address
Phone