Treynor Community School
Health Examination Card

Last Name _____ First Name _____ Birthdate _____ Male Female Sex

Name of Parent or Guardian _____ Address _____ Phone Number _____

Name of Physician _____ Office Phone Number _____

Physical Examination

General Appearance _____ Height _____ Weight _____
Nutritional Status _____ Urinalysis _____ Hematocrit or hgb. _____
Skeletal Development _____ Posture _____ Scoliosis _____
Scalp and skin _____ Lymph nodes _____ Neck _____
Ears _____ Nose _____ Throat _____
Mouth _____ Teeth and gums _____ Speech _____
Heart _____ Rhythm _____ Rate _____ Bl. Pressure _____
Lungs _____ Resp. rate _____
Abdomen _____ Hernia _____
Neurological exam _____
Mental development assessment _____

Health History: (Check any past or present illness the school should be aware of)

_____ chicken pox
_____ epilepsy
_____ diabetes
_____ allergies
_____ asthma
_____ kidney infections
_____ heart disease
_____ surgeries
_____ physical impairments
_____ serious injuries

Other: _____

Vision Screening:

Without correction
Right eye 20/
Left eye 20/

With correction
Right eye 20/
Left eye 20/

Hearing Screening: Pass Fail

1. Is this child subject to any illness which may result in a classroom emergency? Yes No
   If yes, please explain: _____
2. Does this child have any limitations? Yes No
   If yes, please explain: _____
3. Please list any medications this child is taking: _____

Blood lead test:
Date of completion: _____
Results: _____

_____ Date of exam

_____ Signature of Licensed Medical Physician