MOUNT AVIAT ACADEMY
399 CHILDS ROAD
P O BOX 85
CHILDS, MARYLAND 21916-0085
410-398-2206   FAX 410-398-8063

STUDENT HEALTH FORM

Name ____ Sex: M ___ F ___ Birth Date ____________ Grade ___

Address ____

PART I – To be completed by parent before the Physical Examination

HEALTH ISSUES
To the best of your knowledge, please confirm if your child has a history of any of the following:

	COMMENTS
ALLERGIES	
ASTHMA	
BLEEDING PROBLEMS	
CARDIAC PROBLEMS	
CHICKEN POX	
DIABETES	
EPILEPSY/SEIZURES	
EYE PROBLEMS	
FREQUENT EAR INFECTIONS	
FREQUENT EPISODES OF STREP THROAT	
FREQUENT HEADACHES	
HEAD INJURIES/CONCUSSIONS	
HEARING DEFICITS	
HEPATITIS	
LEAD POISONING	
LYME DISEASE	
MENINGITIS	
MONONUCLEOSIS	
RECENT HOSPITALIZATIONS	
RECENT SURGERIES	
SCARLET FEVER	
SICKLE CELL ANEMIA	
SPEECH PROBLEMS	
TUBERCULOSIS	
VISION DEFICITS	

Are there any other medical conditions not listed above that are pertinent to your child? ______________________________
____
____
____

List any medications that your child takes routinely or seasonally. ______________________________
____
____

OVER

PART II – To be completed by Examining Physician or Practitioner

Does this student have a health condition, which may require **EMERGENCY INTERVENTION** while he/she is at school: (E.g., seizure, insect sting, asthma, bleeding problem, diabetes, cardiac problem?) If yes, please **DESCRIBE.**

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Is there any evidence for concern in the areas listed below? If so, please indicate by placing an ✔ in the appropriate space and **DESCRIBE YOUR FINDINGS AND RECOMMENDATIONS.**

HEALTH AREA	**YES**	**NO**	**PHYSICAL FINDINGS AND RECOMMENDATIONS**
VISION			R 20/ Corrected To 20/ L 20/ Corrected to 20/
HEARING			R L
SPEECH/LANGUAGE			
DEVELOPMENT			
ADD/ADHD			
PHYSCIAL IMPAIRMENT			
IMMUNODEFICIENCY			
LEAD POISONING			
LUNGS			
HEART			BP __________ Pulse ____________
ABDOMEN			
HERNIA			
EXTREMETIES			
SKIN--SCALP			
EARS			
NOSE			
THROAT			
TEETH			
GLANDS			
MENSTRUATION			
SCOLIOSIS SCREENING FOR ALL MIDDLE (5-8TH) GRADE STUDENTS			
			HEIGHT ______________ **WEIGHT** ____________________

Should there be any restriction of physical activity in school? If so, specify nature and duration of restriction.

____

____

Is the student on long-term medication? If so, please **describe**.

____

____

Immunizations given at this visit: ____

Physician's Signature ____ **Date** ____________________