STATE OF FLORIDA
DEPARTMENT OF HEALTH & REHABILITATIVE SERVICES

STUDENT HEALTH EXAMINATIONS

Date _____

Student's Full Name _____ Phone _____ Age _____ Race _____ Sex _____

Address _____ Birthdate _____

Name of Parent or Guardian _____ School _____

A. HEALTH EXAMINATION

Height _____ Weight _____ Blood Pressure _____

(✓) Normal=N; Abnormal=A	N	A	COMMENT: Abnormal Findings, by number
1. Appearance			
2. Skin/Nose			
3. Head/Scalp			
4. Eyes			
5. Visual Acuity (R & L)			
6. Ears			
7. Auditory Acuity (R & L)			
8. Nose / Throat			
9. Mouth, Teeth and Gums			
10. Chest / Lungs			
11. Heart			
12. Abdomen			
13. Genitals and Anus			
14. Musculo-Skeletal			
15. Neurological			
16. Alertness			
17. Emotional / Mental/ Behavior Prob.)			
18. Handicap, physical/ other (Specify)			
19. Activity Restrictions (Specify)			
20. Abuse, substance/ physical / emotional			
21. Nutrition			
22. Other			

B. HEALTH HISTORY (Serious Illnesses Injuries: explain) _____

(attach narrative if additional space needed)

C. LABORATORY (as indicated)

Hemoglobin/Hematocrit _____ Stool (O & P) _____ Tuberculin test: type _____ date _____ results _____

Lead _____ Sickle Cell _____

NAME: _____

TITLE: _____

ADDRESS: _____

(Please Print)

_____ Authorized Signature

_____ Date

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