The Harvey School **Health Examination Form**

260 Jay Street, Katonah, NY 10536

Student: _____

D.O.B.:	Height:	Weight (BMI):	Blood Pressure:

IMMUNIZATION RECORD

	Initial Series	Booster	Disease
Polio Vac (OPV or IPV)			
DTAP			
Dipth – Tetanus			
M.M.R.			
HIB Vaccine			
Hepatitis A Vaccine			
Hepatitis B Vaccine			
Varicella Vaccine			
TB Test (Tine or PPD)			
Other (Gardisil)			

PHYSICAL EXAMINATION (Blank if normal)

Abdomen	Neurologic
Albumin	Nose
Blood Chemistries	Nutrition
Blood lead	Orthopedic
Ears	Scoliosis
Eyes	Skin
Genito-urinary	Speech
Glands	Sugar
Heart	Teeth
Hernia	Tonsils
Lungs	Urinalysis

PAST MEDICAL HISTORY (Blank if normal)

Allergies	Injuries
Asthma	Measles
Chicken Pox	Medications
German Measles	Mumps
Illness	Operations

PATIENT IS SUBJECT TO (Blank if none)

Bronchitis	Enuresis
Chronic constipation	Epistaxis
Colds & sore throats	G.I. disturbances
Earaches	Headaches

Can patient lead a normal school life, including a full athletic program? (Circle one) Yes No

Recommendations for follow-up or modification of school program due to any abnormalities noted:

_____

_____

_____

Examining Physician's Name: _____
Physician's Address: _____
Physician's Phone: _____ Physician's Fax: _____
Examining Physician's Signature: _____ Date: _____

AUTHORIZATION FOR ADMINISTRATON OF MEDICATION IN SCHOOL

PLEASE NOTE: Medications, including non-prescription drugs, can only be dispensed if this section is completed and signed by both the student's parent and prescribing physician.

_____ is to receive _____ for
(Student's name) (Medication)

_____
(Diagnosis of condition)

_____
(Dosage & frequency of medication)

Purpose of medication: _____
Possible side effects: _____

The school nurse or her designee may safely dispense the following PRN medications to student:
□ Advil □ Antacids □ Benadryl □ Cough drops □ Robitussin □ Sudafed □ Tylenol

Prescribing Physician's Name: _____
Physician's Address: _____
Physician's Phone: _____ Physician's Fax: _____
Prescribing Physician's Signature: _____ Date: _____

I hereby give permission for the school nurse to administer to my child the above-stated medication in the dosage and frequency that is prescribed above by my child's physician. I will furnish all medication in the properly labeled original container from the pharmacy. I understand that the school nurse (or other designated person in case of absence of the school nurse) will administer the medication and that all medication (including non-prescription drugs) must be kept in the Infirmary.

Signature of Parent or Guardian: _____ Date: _____