UNION COUNTY TEAMS CHARTER SCHOOL

**COMPLETE AND RETURN SEPT. 7, 2017**

*Union County TEAMS Charter School and High School/College Academy*

# 20__ - 20___ HEALTH SERVICES/HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

Dear Parent/Guardian: _____

**NOTE: ALL PHYSCIALS MUST BE CURRENT.** Please present this form to your physician at the time of your examination. Upon completion, please return to the school.

**(ATTACH UPDATED IMMUNIZATION RECORD)**

HEIGHT: _____ WEIGHT: _____ B.P.: _____ PULSE: _____ URINE: _____ PROTEIN: _____ SUGAR: _____

VISION: RIGHT: _____ LEFT: _____ BOTH: _____ GLASSES: RIGHT: _____ LEFT: _____ BOTH: _____

| PHYSICAL FINDINGS | NORMAL | ABNORMAL | SPECIFY AND RECOMMEND |
|---|---|---|---|
| EYES | | | |
| VISION | | | |
| COLOR PERCEPTION | | | |
| EARS – OTOSCOPIC | | | |
| HEARING: RIGHT | | | |
| HEARING: LEFT | | | |
| TEETH/MOUTH | | | |
| NOSE | | | |
| THROAT | | | |
| LYMPH GLAND | | | |
| THYROID | | | |
| HEART | | | |
| LUNGS | | | |
| ABDOMEN | | | |
| HERNIA | | | |
| GENITO-URINARY | | | |
| ORTHOPEDIC (STRUCTURAL) | | | |
| SCOLIOSIS SCREENING | | | |
| SKIN | | | |
| NUTRITION | | | |
| NERVOUS SYSTEM | | | |
| SPEECH | | | |
| OTHER | | | |

**-over-**

STUDENT'S NAME: _____

DATE OF MOST RECENT TUBERCULIN TEST (MANTOUX): _____

RESULT: _____ FOLLOW-UP: _____

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DATES OF MOST RECENT IMMUNIZATION GIVEN, OR DATES OF ALL IMMUNIZATIONS FOR NEWLY REGISTERED STUDENTS ENROLLING IN PRE-K OR KINDERGARTEN:

POLIO: _____ DTP: _____ DT: _____

MEASLES: _____ RUBELLA: _____ MUMPS: _____

OTHER: _____

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PLEASE LIST ANY HEALTH PROBLEMS WHICH MAY INTERFERE WITH THE STAFF MEMBER'S EDUCATIONAL PROGRAM OR LIMIT HIS/HER PARTICIPATION IN THE REGULAR SCHOOL PROGRAM AND INDICATE ANY RESTRICTIONS:

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_____ _____

DATE OF EXAMINATION PHYSICIAN SIGNATURE

PRINTED NAME AND ADDRESS OF PHYSICIAN:

_____

_____

_____