# STUDENT HEALTH REVIEW/EXAM

**SECTION A: To be completed by parent or guardian.**

| Student Last Name | Student First Name | MI | Date of birth | Grade |
|---|---|---|---|---|
| | | | _____/_____/_____ | |

| Address | City | Zipcode |
|---|---|---|
| | | |

| Phone | Emergency Phone | Date of last physical exam |
|---|---|---|
| | | _____/_____/_____ |

| Last tetanus shot | Last measles shot | Last TB skin test | TB skin test result | TB status |
|---|---|---|---|---|
| _____/_____/____ | _____/_____/___ | _____/_____/___ | | |

| | | YES | NO |
|---|---|---|---|
| **1.** | Have you ever been hospitalized? | ❑ | ❑ |
| | Have you ever had surgery? | ❑ | ❑ |
| **2.** | Are you presently taking any medications or pills? | ❑ | ❑ |
| **3.** | Do you have any allergies *(medicine, bees or other stinging insects)*? | ❑ | ❑ |
| **4.** | Have you ever passed out during or after exercise? | ❑ | ❑ |
| | Have you ever been dizzy during or after exercise? | ❑ | ❑ |
| | Have you ever had chest pain during or after exercise? | ❑ | ❑ |
| | Do you tire more quickly than your friends during exercise? | ❑ | ❑ |
| | Have you ever had high blood pressure? | ❑ | ❑ |
| | Have you ever been told that you have a heart murmur? | ❑ | ❑ |
| | Have you ever had racing of your heart or skipped beats? | ❑ | ❑ |
| | Has anyone in your family died of heart problems or sudden death before age 50? | ❑ | ❑ |
| **5.** | Do you have any skin problems *(itching, rashes, acne)*? | ❑ | ❑ |
| **6.** | Have you ever had a head injury? | ❑ | ❑ |
| | Have you ever been knocked out or unconscious? | ❑ | ❑ |
| | Have you ever had a seizure? | ❑ | ❑ |
| | Have you ever had a stinger, burner or pinched nerve? | ❑ | ❑ |
| **7.** | Have you ever had heat or muscle cramps? | ❑ | ❑ |
| | Have you ever been dizzy or passed out in the heat? | ❑ | ❑ |
| **8.** | Do you have trouble breathing or do you cough during or after activity? | ❑ | ❑ |
| **9.** | Do you use any special equipment *(pads, braces, neck rolls, mouth guards, eye guards, etc.)*? | ❑ | ❑ |
| **10.** | Have you ever had problems with your eyes or vision? | ❑ | ❑ |
| | Do you wear glasses or contacts or protective eye wear? | ❑ | ❑ |
| **11.** | Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? | ❑ | ❑ |
| | ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest<br>___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand | | |
| **12.** | Have you ever had other medical problems *(infectious mononucleosis, diabetes, etc.)*? | ❑ | ❑ |
| **13.** | Have you had any medical problem or injury since your last evaluation? | ❑ | ❑ |
| **14.** | When was your first menstrual period? _____ | | |
| | When was your last menstrual period? _____ | | |
| | What was the longest time between your periods last year? _____ | | |

Explain all "yes" answers: _____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

**Seoul American High School**
Unit # 15549 APO , AP 96205 Phone: 99-797-3667

# STUDENT HEALTH REVIEW/EXAM

**SECTION B: To be completed by physician, physician assistant or advanced nurse practitioner**

| Student Last Name | Student First Name | MI | Date of birth | Grade |
|---|---|---|---|---|
| | | | _____/_____/_____ | |

| Height | Weight | Blood Pressure | Pulse |
|---|---|---|---|
| | | | |

| Vision — Right Eye | Vision — Left Eye | Vision Corrected? | Pupils |
|---|---|---|---|
| 20/ | 20/ | ❑ Yes ❑ No | |

| | NORMAL | ABNORMAL FINDINGS | INITIALS |
|---|---|---|---|
| Cardiopulmonary | | | |
| Pulse | | | |
| Heart | | | |
| Lungs | | | |
| Tanner Stage | 1 | 2 3 4 5 | |
| Skin | | | |
| Abdominal | | | |
| Genitalia | | | |
| Musculoskeletal | | | |
| Neck | | | |
| Shoulder | | | |
| Elbow | | | |
| Wrist | | | |
| Hand | | | |
| Back | | | |
| Knee | | | |
| Ankle | | | |
| Foot | | | |
| Other | | | |

**Clearance:**

❑ Cleared

❑ Cleared after completed evaluation/rehabilitations for: _____

❑ Not cleared for: ___ Collision ___ Contact ___ Noncontact ___ Strenuous
___ Moderately Strenuous ___ Nonstrenuous

Due to: _____

| Name of M.D., P.A. or ANP (circle which) | Signature | Date |
|---|---|---|
| | | _____/_____/_____ |

| Address | Phone |
|---|---|
| | |