Health Office 973-635-1700 **ECLC SCHOOL HEALTH APPRAISAL** **HR _____**
FAX 973-635-2845 **2022-2023**

PARENT Complete this portion: Returning Student_____New Student_____

STUDENT NAME_____ BIRTHDATE_____/_____/_____ AGE_____

HOME ADDRESS_____

NAME OF PARENTS (or Guardian)_____

HOME PHONE _____ CELL PHONE _____

CELL PHONE _____ WORK PHONE _____

E-MAIL ADDRESS_____

PRIMARY CARE PHYSICIAN_____ PHONE _____

DENTIST _____ PHONE _____

OTHER MD _____ SPECIALTY _____ PHONE _____

OTHER MD _____ SPECIALTY _____ PHONE _____

PHYSICIAN Complete this report of physical exam: **DATE OF EXAM** _____

HT _____ WT _____ BP _____ HR _____ RR _____ T _____

DISTANCE VISION _____ NEAR VISION _____ GLASSES/CONTACTS _____

HEARING RIGHT _____ HEARING LEFT _____

GENERAL CONDITION _____ NUTRITION _____ SKIN _____

HEAD _____ EYES _____ EARS _____

NOSE _____ MOUTH/THROAT _____ DENTAL _____

TONSILS/ADENOIDS _____ NECK/THYROID _____ LYMPH NODES _____

HEART _____ LUNGS _____ ABDOMEN _____

GENITO-URINARY _____ TANNER STAGE _____ HERNIA _____

MUSCLE-SKELETAL _____ MUSCLE TONE _____ GAIT _____

SPINE/SCOLIOSIS_____ NEUROLOGICAL _____ SEIZURE DISORDER _____

DATE OF MOST RECENT SEIZURE_____ TYPE OF SEIZURE _____

DIAGNOSIS/DESCRIPTION OF HEALTH CONDITIONS:

1. _____

2. _____

3. _____

ALLERGIES _____

DIET RESTRICTIONS _____

MEDICATION:

NAME/DOSE _____

NAME/DOSE _____

NAME/DOSE _____

IMMUNIZATIONS: **ATTACH IMMUNIZATION RECORD**

COVID-19 VACCINE:

NAME/1st DOSE _____ NAME/2nd DOSE _____

STUDENTS WITH DOWN SYNDROME/TRISOMY 21- *WAS AN X-RAY PERFORMED TO DETERMINE CERVICAL STABILITY*?

YES (**ATTACH REPORT OF ATLANTO-AXIAL X-RAYS**) _____ NO _____

TWO STEP TUBERCULOSIS (MANTOUX) TEST- *REQUIRED FOR STUDENTS 17-21 YEARS OLD IN WORK PROGRAM*

1. DATE PLACED _____ DATE READ _____ RESULT _____

2. DATE PLACED _____ DATE READ _____ RESULT _____

I HAVE EXAMINED THIS STUDENT AND REVIEWED THEIR HEALTH HISTORY. THIS STUDENT IS MEDICALLY CLEARED TO PARTICIPATE IN SCHOOL ACTIVITIES AND PHYSICAL EDUCATION.

NAME OF HEALTH CARE PROVIDER _____

SIGNATURE _____ DATE _____

HEALTH CARE PROVIDER STAMP: