The Oakwood School - Student Health Record
Health Care Provider's Examination

Name ______________________ ☐ Male ☐ Female Date of Birth __________ Academic Yr ______

Pertinent Family History ____

Current Health Issues

Y	N	
☐	☐	Allergies: Please List: Medications __________ Food __________ Other __________ History of Anaphylaxis to __________ Epi-Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes (please attach) ☐ No
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: ______________________________
☐		Other (please specify): ______________________________

Current Medications *(if relevant to the student's health and safety) Please circle those administered in school.*

Physical Examination Date of Examination __________

Hgt: ________(_____%) Wgt: _______(_____%) BMI: _______(_____%) BP: __________

(Check = Normal / If abnormal, please describe)

☐ General __________	☐ Lungs __________	☐ Extremities __________
☐ Skin __________	☐ Heart __________	☐ Neurologic __________
☐ HEENT __________	☐ Abdomen __________	☐ Other __________
☐ Dental/Oral __________	☐ Genitalia __________	

Screening:

	Pass	Fail		Pass	Fail		Pass	Fail
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead ________ Date__________ ☐ Other __________

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High Risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors)

Date of PPD: __________ Results: _______ mm

Referred for evaluation to: ______________________ ☐ Low Risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behaviour ☐ Other

Comments/Recommendations: ______________________________

☐ Yes ☐ No ***This student may participate fully in the school's programs, including physical education and competitive sports. If no, please list restrictions:*** ______________________________

____

Signature of Examiner (circle): MD, DO, NP, PA Date __________ Please print name of Examiner

Group Practice ______________________ Telephone __________

Address ______________________ City __________ State ______ Zip Code ______

Return form to The Oakwood School, 4000 MacGregor Downs Road, Greenville, NC 27834

Please attach any additional information as needed for the health and safety of the student.