PINE COBBLE SCHOOL

163 Gale Road • Williamstown, MA 01267 • 413-458-4680

STUDENT HEALTH FORM

All information in this health form is considered confidential and will be used only for the purpose of evaluating health status and facilitating medical diagnosis, care and/or treatment. **This form must be completed by your child's physician along with his/her complete immunization record and returned to Pine Cobble School prior to the student's first day of class.**

Pine Cobble School does not conduct health examinations as the state requires for all public school students. It is, therefore, recommended that parents consult with their health care providers to ensure that these exams are carried out for their children.

o **Male** o **Female**

Name_____

Last **First** **Middle** **Date of Birth**

Current Health Issues:

Y	**N**	
o	o	**Allergies:** Please list: Medications_____
		Food_____ Other_____
		History of Anaphylaxis to _____ Epi-Pen®: Yes No
		Food Allergy Action Plan: Yes No (*Please attach if Yes*)
o	o	**Asthma:** Asthma Action Plan: Yes No *(Please attach if Yes)*
o	o	**Diabetes:** Type I Type II
o	o	**Seizure Disorder:**_____
o	o	**Other** *(Please specify)*_____

Current Medications: _____

Pertinent Family History: _____

_____

Physical Examination: **Date of Examination:** _____

Height: _____(_____%) Weight: _____(_____%) BP: _____

(Check = Normal; If abnormal, please describe.)

o General _____ o Lungs _____ o Extremities _____

o Skin _____ o Heart _____ o Neurologic _____

o HEENT _____ o Abdomen _____ o Other _____

o Dental/Oral _____ o Genitalia _____

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

Laboratory Results: o Lead_____ Date_____ o Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing:

o 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: _____

o Low risk (no PPD done)

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

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

o Emotional/Social o Behavior o Other

Comments/Recommendations: _____

o Y o N This student may participate fully in the school program, including physical education and competitive sports.

If no, please list restrictions: _____

o Y o N Immunizations are complete. Please attach a complete immunization record. If no, give reason and attach.

_____ _____ _____

Physician's Signature Date Please PRINT physician's name

_____ _____

Group Practice & Address Telephone

Please attach student's complete immunization record.