

MINERVA CENTRAL SCHOOL
HEALTH EXAMINATION FORM

Today's Date _____

Name _____

DOB _____

Eyes R _____ L _____

Height _____ Weight _____

Ears R _____ L _____

Specific Dates of Immunizations

Lymph Nodes _____

DPT: _____

Thyroid _____

MMR: _____

Breast _____

OPV/IPV(specify) _____

Nose _____

Tonsils _____

HepB _____

Teeth _____

Hib _____

Heart _____

Tine Test _____

BP _____

Health History _____

Lungs _____

Previous Illness _____

Hernia _____

Genito-Urinary _____

Surgery _____

Orthopedic -Structural

Chronic Conditions _____

Scoliosis Screening

Physical Limitations _____

Posture _____

Any restrictions to full participation in
Physical Education? _____

Feet _____

Skin _____

Nervous System _____

For secondary students: Please check if
Qualified for interscholastic sports

Nutrition _____

Contact _____

Speech _____

Non-contact Endurance _____

Other _____

Other _____

Urinalysis: Protein Glucose

Physician's Name _____

Physicians Signature _____

Address _____

Phone Number _____