



TO BE COMPLETED BY A HEALTHCARE PROVIDER

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STUDENT NAME :					DATE OF BIRTH (dd/m	m/yyyy) :
PARENT / GUARDIAN NAME (S) :					SCHOOL ATTENDED :	
HEALTHCARE PROVIDER / DOCTOR :					DATE OF EXAMINATION :	
IMMUNIZATIONS						
Attach a copy of the in	nmunization red	cord.				
PERTINENT ILLNESS,	COMMUNICAB	LE DISEASES, RI	ISKS, OR DEVELOPN	MENT PROBLEM	n s	Please check all that apply.
[] ALLERGIES If yes, please list:				[] ASTHMA		[] ATTENTION / LEARNING
[] BLEEDING DISORDER				[] CANCER / LEUKEMIA		[] CEREBRAL PALSY
[] CHICKEN POX If yes, date:				[] CYSTIC FIBROSIS		[] DENTAL PROBLEMS
[] DIABETES				[] EMOTIONAL / BEHAVIOR		[] ENCOPRESIS
[] ENURESIS				[] GENETIC DISORDER		[] HEART CONDITIONS
[] HEARING DISORDER				[] HEPATITIS		[] KIDNEY DISORDER
[] LEAD LEVEL If yes, test done: [] YES [] NO At risk: [] YES [] NO				[] OBESITY		[] ORTHOPEDIC CONDITION
[] PNEUMONIA				[] SEIZUR	E / CONVULSIONS	[] SICKLE CELL ANEMIA
[] SPEECH / LANGUAGE						
[]SPEECH / LANGUAGE				[]TUBER	CULOSIS	[] VISION
[] OTHER If yes, please li		apply:		[]TUBER	CULOSIS	[] VISION
		арріу:		[]TUBER		
[] OTHER If yes, please li	ase explain all that a	apply:		[]TUBER	SUMMARY OF FIN	
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NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.

PROVIDER'S SIGNATURE

DATE