Horseheads Central School District

Private Physician Health Evaluation

Name: _____ Birthdate: _____

Address:_____ Phone: _____

_____

School: _____

The above child has been evaluated with respect to his/her health with the following results:

Height: _____ Weight: _____ Blood Pressure: _____

Hearing: _____ Vision: _____

Medical History: Normal, except for:

Physical Development: Normal, except for:

Intellectual Development: Normal, except for:

Emotional Development: Normal, except for:

This child may participate in regular programs as follows:

Academic _____ Physical/Sports _____ Swimming _____ Exceptions:

Other Recommendations:

_____

Immunizations and Tests:

DPT/DT _____ _____ _____ _____ _____

TETANUS _____ MMR _____ _____

TOPV _____ _____ _____ _____

VARICELLA _____ _____
(immune) (disease)

HEPB _____ _____ _____ OTHER _____ TINE _____

URINALYSIS: _____ / _____ HCT: _____ / _____

_____ _____
Print Name of Examiner Signature

_____ _____
Print Address Date