PHSSN HEALTH FORM

This form MUST be completed before enrollment is finalized!

To the examining health care provider; Please review the student's past medical history on this form and complete the information below. Please comment *on* all positive responses. **The reverse side of this form is to be completed by the student but MUST also be signed by the health care provider. According to Texas State Law, evidence of a current TB and immunization MUST be provided.**

Student's First Name: ___________________ Last: ____________________
Middle:_________________ Date of Birth:_____________ SS#________________
Sex: _____________ Citizenship: _______________

IMMUNIZATION REQUIRED

IMMUNIZATION REQUIRED	Date of FIRST Injection: (month-date-year)	Date of SECOND Injection: (month-date-year)	Titer (positive/ negative)
RUBELLA			
MEASLES-RUBEOLA			
MUMPS			
CHICKEN POX			

	1ST SHOT	2ND SHOT	3RD SHOT	TITER (POS/NEG)
HEPATITIS B SERIES				

	SERIES COMPLETE	DATE OF LAST INJECTION
POLIO		
TETANUS/DIPTHERIA		

**It is highly recommended that if you have not had Chicken Pox, that you get the Chicken Pox vaccine.*

TUBERCULIN SKIN TEST: Positive ________ Negative______ Date:_______________
If TB test positive, chest x-ray date: ________________ Results:____
_(must be current with past 12 months)
__Medication:____

Blood Pressure:
Corrected Vision: Right 20/_ . Left 20/_ Height:_ . Weight:_
Are there any abnormalities of the following systems? If so, attach a description on separate page.

_YES __ NO Head, ears, nose or throat
_YES __ NO Respiratory
_YES __ NO Cardiovascular
_YES __ NO Gastrointestinal
_YES __ NO Hernia
_YES ___NO Eyes
_YES ___NO Genitourinary
_YES ___NO Musculoskeletal
_YES ___NO Metabolic/Endocrine
_YES ___NO Neuropsychiatry
_YES ___NO Skin
_YES ___NO Loss or impaired function of any organ
_YES ___NO Limited physical activity
_YES ___NO Is the student now under treatment for any medical or emotional condition? (if yes, describe)
_YES ___NO Any general comments or recommendations regarding the care of this student? (if yes, describe)

SEE REVERSE SIDE OF THIS FORM!

TO BE COMPLETED BY STUDENT

Past Medical History:

Have you had any of the following? Please answer each, commenting on all positive replies below. Use additional paper if necessary.

__Yes __No Scarlet Fever
__Yes __No Measles
__Yes __No German measles
__Yes __No Mumps
__Yes __No Chicken Pox
__Yes __No Malaria
__Yes __No Dental problems
__Yes __No Sinusitis
__Yes __No Eye trouble
__Yes __No Ear, Nose
__Yes __No Insomnia
__Yes __No Frequent anxiety
__Yes __No Recurrent headache

__Yes __No Recurrent Colds
__Yes __No Head injury w/unconsciousness
__Yes __No Hay fever, asthma
__Yes __No Tuberculosis
__Yes __No Shortness of breath
__Yes __No Pain/pressure in chest
__Yes __No Heart palpitation
__Yes __No Chronic cough
__Yes __No High/low blood pressure
__Yes __No Rheumatic fever or heart murmur
__Yes __No Disease or injury to joints
__Yes __No Knee/shoulder pain
__Yes __No Menstrual problems

__Yes __No Stomach or Intestinal problems
__Yes __No Tumor, cancer, cyst
__Yes __No Jaundice
__Yes __No Gallbladder problems
__Yes __No Diabetes
__Yes __No Recent weight loss
__Yes __No Recent weight gain
__Yes __No Epilepsy
__Yes __No Dizziness, fainting
__Yes __No Weakness, paralysis
__Yes __No Albumin/sugar in urine
__Yes __No Frequent urination
__Yes __No Seizures

Comments:____

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Please list any prescriptive medication or over the counter medication that you take on a regular basis:____

____

Please list all surgeries:____

____

Please list any allergies

__Yes __No Medications____
__Yes __No Foods ____
__Yes __No Environment____

__Yes __No Has your physical activity been restricted during the past five years? Give reason and duration.
__Yes __No Have you been diagnosed with Attention Deficit Disorder or ANY learning disability?
__Yes __No Have you received treatment or counseling for a nervous condition or emotional problem? Give details.
__Yes __No Have you had any illness or injury or been hospitalized for reasons other than already noted? Give details.
__Yes __No Have you visited physicians or other professionals in the past five years for other than routine checkups?

____ ______________________________
Health Care Provider's Signature (acknowledging review) **Date**

____ ______________________________
Student's signature **Date**