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/ PERTUSSIS		

**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 Recurrent Colds	__Yes __No Stomach or Intestinal problems
__Yes __No Measles	__Yes __No Head injury w/unconsciousness	__Yes __No Tumor, cancer, cyst
__Yes __No German measles	__Yes __No Hay fever, asthma	__Yes __No Jaundice
__Yes __No Mumps	__Yes __No Tuberculosis	__Yes __No Gallbladder problems
__Yes __No Chicken Pox	__Yes __No Shortness of breath	__Yes __No Diabetes
__Yes __No Malaria	__Yes __No Pain/pressure in chest	__Yes __No Recent weight loss
__Yes __No Dental problems	__Yes __No Heart palpitation	__Yes __No Recent weight gain
__Yes __No Sinusitis	__Yes __No Chronic cough	__Yes __No Epilepsy
__Yes __No Eye trouble	__Yes __No High/low blood pressure	__Yes __No Dizziness, fainting
__Yes __No Ear, Nose	__Yes __No Rheumatic fever or heart murmur	__Yes __No Weakness, paralysis
__Yes __No Insomnia	__Yes __No Disease or injury to joints	__Yes __No Albumin/sugar in urine
__Yes __No Frequent anxiety	__Yes __No Knee/shoulder pain	__Yes __No Frequent urination
__Yes __No Recurrent headache	__Yes __No Menstrual problems	__Yes __No Seizures

Comments: _____

_____

_____

_____

_____

_____

_____

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**