# General Health Examination

***Return form to River Grove prior to the first day of entrance***

**Parent/Guardian: Complete this top portion**

Name ______________________________ ☐ M ☐ F Birth Date ____________
(Last) (First) (Middle)

Parent/Guardian Name(s) ______________________ Home Phone ____________

Significant Past Health History or present illness: ______________________

Health History

| | Yes | No | Remarks |
|---|---|---|---|
| Chronic Recurrent Illness | | | |
| Serious Injury (bone, joint, head) | | | |
| Hospitalizations/ ER visits | | | |
| Asmtha | | | |
| Diabetes | | | |
| Seizures | | | |

| | Yes | No | Remarks |
|---|---|---|---|
| Headaches | | | |
| Vision Impairment | | | |
| Hearing Impairment | | | |
| Kidneys | | | |
| Fainting | | | |
| Recurrent Skin Problem | | | |
| Other | | | |

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**Physical Health Examination (examining practitioner to complete this section):**

Vision: R 20/________ L 20/________ Corrected: ☐ Yes ☐ No Hearing by 20db audiometry: R ________ L ________

Height ________in. Weight________lbs. BMI ________% BMI ________ Blood Pressure ________ /________

Allergies ______________________ Current medications ______________________

| | Normal | Abnormal | Remarks |
|---|---|---|---|
| Eye | | | |
| cover test | | | |
| corneal reflection | | | |
| ENT | | | |
| Dental | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen | | | |

| | Normal | Abnormal | Remarks |
|---|---|---|---|
| Genitourinary | | | |
| Skin | | | |
| Extremities | | | |
| Musculoskeletal | | | |
| Spine/scoliosis | | | |
| Nutritional status | | | |
| Emotional status | | | |
| | | | |

**Sports/Physical Education approved?** ☐ Yes ☐ No Limitations: ______________________

School sports approved? ☐ Yes ☐ No Limitations: ______________________

Health Care Provider Signature ______________ Print Name ______________ Exam Date ________

Clinic Name ______________ Phone ______________ Fax # ______________