

State of Illinois Certificate of Child Health Examination

Student's Name	Turk may	tering its papers against	Birth Date	Sex	Race	/Ethnicity	Scho	ol /Grade Level/ID#
Last	First	Middle	Month/Day/Year			111	TUREOU	orikan terikuh esilen biar
THE RESIDENCE OF THE PARTY OF T	reet City	Zip Code	Parent/Guardian		STREET, SQUARE, SQUARE,	one # Home	1 16	Work
medically contraine	S: To be completed be dicated, a separate w	ritten statement mus	st be attached by the					
REOUIRED	ning the medical reas	DOSE 2	DOSE 3	DOSE 4		DOSE 5		DOSE 6
Vaccine / Dose	MO DA YR	MO DA YR	MO DA YR	MO DA	YR		YR	MO DA YR
DTP or DTaP	0.4 127	\$4 (2050)(57) .ng (1) so	(Abbady)		Told 1	esY to		sesumate instrong fits
Tdap; Td or Pediatric DT (Check specific type)	□Tdap□Td□DT	□Tdap□Td□DT	□Tdap□Td□DT	□Tdap□Td□	□DT	□Tdap□Td□	IDT	□Tdap□Td□DT
Polio (Check specific type)	□ IPV □ OPV	□ IPV □ OPV	□ IPV □ OPV		OPV		PV	□ IPV □ OPV
Hib Haemophilus influenza type b		\$1000 (10)	zonyne i zonengió		09	BY DA	i kuzek	region per en march
Pneumococcal Conjugate	AGNAGA Interactivating	npleted by ND/DQ H	mand of welled neith may	'S Enderso Hilde	MENT	28 [GLOL11KE 3 sees tile		TEMPORAL LADISTIN
Hepatitis B	all done'l geometri	idi To oka yashaA 📑	told Clear yestage	27:04(1/1)	87.7 (4	a kon azaračena	rozni	NBETTS SUREESIN
MMR Measles Mumps, Rubella	La ora Euro i tamangun Gol nj ented deg center	enter a processor promises in lexences on public so	nativos ir gras attenti attenti ango dalipian	Comments:	entarens contáre	* indicates inv	valid d	lose
Varicella (Chickenpox)	than 9	Blood less Date	VedD NeD	test bullearest				
Meningococcal conjugate (MCV4)	antico educio maseta E e e e escribi e beca	III. of Seo Inserviçõe on in Englishe en 112 an 113	nt det keld guibeliet zoo P zandsbag 10	g terredgelen kent Er milhere sock				
RECOMMENDED, E	BUT NOT REQUIRED	Vaccine / Dose	100	Terr Dur Ke				
Hepatitis A	Sec.			-9				
HPV		Cell (vales (hyboked))	State					ropamil'u ngagamat
Influenza		of mental Screening 10	2750			The same trades are a second		eraconor.
Other: Specify Immunization			150					
Administered/Dates Health care provide	er (MD, DO, APN, P.	A, school health prot	fessional, health offic	cial) verifying	above	immunization	histor	v must sign below.
If adding dates to the	above immunization	history section, put y	our initials by date(s)	and sign here.			1115101	J must sign below
Signature		1531(1	Title			Date		100
Signature		lutsbalantu	Title			Date	2	(herea)
ALTERNATIVE P	ROOF OF IMMUNI	TY						NEW TOTAL OF A STATE O
1. Clinical diagnosis copy of lab result. *MEASLES (Rubeola	s (measles, mumps, h	epatitis B) is allowed	panz!	hysician and so				ation. Attach
	Ila (chickenpox) diser rerifies that the parent/guase.							
Date of						apauto, haletta		
Disease		ature	1101 * DM +++	□DL		Title	100	transana atta
	ence of Immunity (ch diagnosed on or after				alleg ger	Varicella A	ttach	copy of lab result.
	diagnosed on or after l						o dist	بالغ المرسود المساور المراس
	rnatives 1 or 3 MUSTs of Immunity MUST			Signature:	X ru Irod		upred	eran ada mada ulawa asay b
Jordan Statement	o or minimum in the out	of Suching to IDII.					-	

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last		First			Middle	Birth Date Month/Day/ Y	oor.	Sex	School		Grade Level/ ID
HEALTH HISTORY	ACCUSED OF THE PARTY OF THE PAR	THE RESERVE AND PERSONS ASSESSMENT	COMPL	ETED	AND SIGNED BY PAREN			BY HE	ALTH CAR	E PR	OVIDER
ALLERGIES (Food, drug, insect, other)	Yes No	List:	ALCOHOLD STREET	CONTRACTOR		MEDICATION (Pre	ACCUSATION AND ADDRESS OF THE PARTY OF THE P	nine management	ist:		Marine parties with a small party and the same and party for the same and
Diagnosis of asthma? Child wakes during n	FURLISHED OF	ning?	Yes Yes	No No		Loss of function of organs? (eye/ear/kid		aired	Yes	No	maz e madro.
Birth defects?			Yes	No		Hospitalizations?			Yes	No	
Developmental delay	?		Yes	No		When? What for?			erič k		rend ranks
Blood disorders? Hen Sickle Cell, Other? E		a tiopag atalitisa	Yes	No	Da noth years and red to seen distract sets ad-	Surgery? (List all.) When? What for?	rano di monese	by beaf	Yes Yes	No	CONTRACTOR
Diabetes?			Yes	No		Serious injury or illa	iess?	ril enzi	Yes	No	examination explaints
Head injury/Concuss		l out?	Yes	No	F REED	TB skin test positive	(past/p	resent)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are t		4.00	Yes	No	- Yo 70% HA	TB disease (past or			Yes*	No	department.
Heart problem/Shortr		Yes	No			Tobacco use (type, frequency)?			No	The transfer of the	
Heart murmur/High blood pressure? Dizziness or chest pain with			Yes	No	INTO SATO A TOD	January Committee of the Committee of th	Alcohol/Drug use?			No	[] [to h] qxb [
Dizziness or chest pa exercise? Eye/Vision problems		Classes I	Yes	No	Last exam by eye doctor	Family history of su before age 50? (Car	ise?)		Yes	No	(500) (51)
Other concerns? (cros						Dental □ Brac	es Li	Впаде	□ Plate	Jiner	sliver have ends
Ear/Hearing problems			Yes	No		Information may be sha Parent/Guardian	red with	appropriate	e personnel for	health	and educational purposes.
Bone/Joint problem/i	njury/scol	iosis?	Yes	No		Signature					Date
PHYSICAL EXAMENT OF THE PROPERTY OF THE PROPER				MEN	TS Entire section be	elow to be completed	by MI		PN/PA BMI PERO	ENTII	LE B/P
- Andrews Control of the Control of					RE) BMI>85% age/sex			0.1 0			y History Yes □ No □
in high prevalence countr No test needed □		e exposed to		Skin	isk categories. See CDC guide Test: Date Read I Test: Date Reported	Result	ov/tb/pi : Posit : Posit	tive 🗆	ns/factsheet Negative D Negative D	10	mg/TB_testing.htm. mm Value
LAB TESTS (Recomm	nended)		Date	T	Results				The second	Date	Results
Hemoglobin or Hem	atocrit					Sickle Cell (wh	nen indi	icated)			390
Urinalysis						Developmental	Screen	-			
SYSTEM REVIEW	Norma	Comme	nts/Fol	ow-up	/Needs			Norma	Commen	ts/Fol	llow-up/Needs
Skin						Endocrine					Linguiseleation
Ears	o cantali	t postani	1874 CO	170d	Screening Result:	Gastrointestin	al	100 A	0.48%	Cal	A Period Committee Committee Co.
Eyes					Screening Result:	Genito-Urina	у	mode	o listatium	mi ay	LMP
Nose		Line			91/1	Neurological					Signature
Throat	1 6.17 - 181	5 E (1	1770000000		2(1)	Musculoskele	tal		Na Depart and the	0.000	and house
Mouth/Dental						Spinal Exam	3 771 -	7330	SPLIT!	U.R	ADDITION OF THE PERSON AND ADDITION OF THE PERSO
Cardiovascular/HT	N					Nutritional st	atus		T. Carlotte		copy of tan remit.
Respiratory	and So b	n interior	ra ritin	ad lor	☐ Diagnosis of Asthr	na Mental Healt		al mas	ali de de	o e	2. Hilliam of a transfer for
Currently Prescribed Quick-relief me	edication	(e.g. Short	Acting			Other	a restric	van Yero	e ataries an	Judi V	Person sugance before venific decreptable for of historic State of
NEEDS/MODIFICA						DIETARY Ne	eds/Rest	rictions	HV.		District
SPECIAL INSTRU	CTIONS	DEVICE	S e.g. sa	fety gla	sses, glass eye, chest protector	for arrhythmia, pacemaker,	prostheti	ic device,	dental bridge,	false to	eeth, athletic support/cup
MENTAL HEALTI					he school should know about school health personnel, check		acher	☐ Couns	elor 🗆 Pr	incipal	igani gan kenani de.
	TION ne		at school	due to	child's health condition (e.g.,	seizures, asthma, insect sting	, food, pe	eanut aller	gy, bleeding	problen	n, diabetes, heart problem)?
On the basis of the exam PHYSICAL EDUCA						(If No		lified pleas	se attach expl		i.)
Print Name		- VV bul.	and the last		(MD,DO, APN, PA)	Signature			- Attorti	urf. io	Date
Address					The state of the s				Phone		



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Student's Name	ALCONOMIC PRODUCTS	-		Andrew State of the Publishers	and the second	apayer lettered	Jenn 1	Birth D	ate		Sex	Race	/Ethnic	ity	Scho	ol/Gra	de Level	/ID#
Last	First				Mid	dle		Month/D	ay/Year			<u> </u>	100					
	reet		City		Zip Code			Parent/G					ne # Ho		MACHEN MACHINE	NASORE RESERVE TO BE	Wo	NASSENWEI BRINSSEEL
IMMUNIZATION medically contrain examination explai	dicated,	sepa	rate w	ritten s	tateme	nt mus	t be at	tached	dyr for by the	health	dose ad care p	minist rovide	ered is r respo	requir ensible	ed. If for co	a speci npletin	fic vacc g the h	ine is ealth
REQUIRED Vaccine / Dose		DOSE 1	YR	мо	DOSE 2 DA			DOSE 3 DA	YR	мо	DOSE 4 DA	YR	мо	DOSE 5 DA	YR	мс	DOSE 6	YR
DTP or DTaP							10000000									\$2.000 ST		
Tdap; Td or Pediatric DT (Check specific type)	□Tdag	□TdE	JDT	□Td	ap□Td	DT	□Tda	ap□Td	□DT	□Tda	ıp□Tdl	JDT	□Tda	ap□Td	⊐DT	□Tda	ap□Tdl	□DT
Polio (Check specific type)	□ IP	V 🗆 (OPV		PV 🗆	OPV		PV 🗆	OPV		PV 🗆 (OPV		PV 🗆	OPV		PV 🗆	OPV
Hib Haemophilus influenza type b							no b											
Pneumococcal Conjugate			7	100 M (PP) (No. 1) 1 (P) (P) (P) (P) 1 (P) (P) (P) (P)		10.00	In its	741.0	deciment		41	DT.	Will)	745		2 1177	777	491-3110 1238-73
Hepatitis B	test un		97/36	dia	10.710	est.		Start 1	XIII CO	2778073		122 3 7	Spiral American St. Science at	the Rot		11-11-1	186 353	
MMR Measles Mumps, Rubella				201 M	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Marian Alexandria (Epilonia)	66.2890 753 203	190 (010		Com	ments:		raffure 161 Au	to kvs		en Les Zous	7 yerka Fagilia	21.0 314.
Varicella (Chickenpox)	14.	44			agar na	lacot:				on Harri Observati								
Meningococcal conjugate (MCV4)	20.000=3 5.000=10		APOUL):				201 pairs	30 g 35 dala	ganaga paren k									
RECOMMENDED, I	BUT NOT	REQU	IRED	Vaccine	/ Dose			P		234 116		A Strates Chescolal						
Hepatitis A				_						2005								
HPV				Mana		-	1000	-				***************************************	_				dts n	
Influenza					Charles Co							Minutes continu						
Other: Specify Immunization Administered/Dates																		
Health care provid	er (MD,	DO, A	PN, P.	A, scho	ol heal	th pro	fession	il, heal	th offi	cial) ve	rifying	above	immu	nizatio	n histo	ry mus	t sign t	elow.
If adding dates to the	e above in	mmuni	zation	history	section	, put y	our init	ials by	date(s)	and sig	n here.							
Signature								Ti	tle					Da	te			
Signature								Ti	tle					Da	te	CONTRACTOR	DESCRIPTION	
ALTERNATIVE P	AND RESIDENCE OF STREET, SPECIAL PROPERTY AND ADDRESS.				THE STATE OF THE S													
1. Clinical diagnosi copy of lab result. *MEASLES (Rubeoli				epatiti:					d by p		n and s					nation.	Attac	h
2. History of varice Person signing below v documentation of disease	verifies tha	t the pa	() dise	ase is a ardian's	cceptal descript	ble if v	erified varicella	by hea disease	Ith car history	e provi	der, scl	nool he ast infec	ealth pr	rofession d is acce	onal or pting su	health ich histo	officia ry as	Limited officers
Date of Disease			Sign	ature									7	Title				
3. Laboratory Evid	lence of I	mmur	ity (cl	heck on	-/	Measle	and the state of t		mps**		Rubella	. []Varie	-	Attac	1 сору	of lab r	esult.
*All measles cases **All mumps cases	diagnose	d on o	rafter	July 1,	2002, r	nust be	confirm	ned by	laborat laborat	tory evic	dence. lence.	tolika etri	100	20.317	THEY	emy	MINES.	12177
Completion of Alte Physician Statement	rnatives	1 or 3	MUST	T be ac	compa	nied by	y Labs	& Physica	sician :	Signatu	re:	a velia	fine plane			POLICE POLICE	b ot add	
Physician Statement	o or min	unity I	MOST	oc subi	mucut	O HOLL	1 101 10	TICYY.	-	-		-	AND DESCRIPTIONS OF THE PERSONS OF T	Chrospon with the American	-	adante de la constitución de la	and the second second	*********

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

				_			ha de Nacimiento	Sexo	Escuela		Grado/Núm. de Ident,
Apellido	ADAGE		Vom				es / Dia / Año	DOD DE C	UDAD	ODEGA	
ALERGIAS (Alimentos		Anótelas tod	_	OU Y FI	RMADO POR PADRES/	TUTURY	ERIFICADO POR EL PROVEE MEDICINAS (Anote todas Si		UIDAD	O DE SA	LUD
drogas, insectos, otro)	, SI No	Anotoias tod	23:				las recetadas o tomadas con regularidad)	- 1			
¿Tiene diagnóstico de asth ¿Despierta el nifto tosiendo		che?	Sí	No			¿Tiene pérdida de funciones en órganos? (Ojos/Oidos/Riñones/		Si	No	
¿Tiene defectos de nacimie	nto?		Sí	No			¿Ha sido hospitalizado?		91	No	
¿Tiene retrasos del desarro			SI	No			¿Cuándo? ¿Para qué?				
¿Tiene problemas de la sar Glóbulos Falciformes (Sic			Sí	No			¿Ha tenido alguna cirugia?(anó: ¿Cuándo? ¿Para qué?			No	
¿Tiene diabetes?			Sí	No			¿Ha tenido heridas graves o enf	ermedades		No	
¿Tieno heridas en la cabez			Si	No			¿Prueba positiva de TB (Pasado			den	i contestó si, refiera al artamento de salud local
¿Tiene convulsiones? Cón			Si	No			¿Enfermedad de TB (Pasado o l	Presento)?	Sí	No	
Tiene problemas cardiaco			Si	No			¿Usa tabaco (tipo, frecuencia)?	******		No No	
¿Tiene soplo en el corazón/presión arterial alta!			1	No			¿Toma alcohol/drogas? ¿Historial de familiares de mue:	rte repentin			
¿Tiene mareos o dolor de pecho al hacer ajercicios?			Sí	No		,	antes de los 50 años? ¿Causa?		Si	No	
¿Problemas con los ojos/vi ¿Otras Preocupaciones? (l	izco, pá	pados caldo:			de Contacto 📮 Último en dificultad cuando lee)	xamen		1 Puente		ncas Ot	
¿Tiene problemas de los o	dos/no o	ye bien?	Sí	No			La información en este formularional salud y educación.	o se puede c	ompartir	con el per	sonal apropiado para propósitos de
¿Tiene problemas de los huesos/articulaciones/heric			Sí	No			Firma del Padre/Tutor				Fecha
PHYSICÄL EXAM HEAD CIRCUMFEREN	unat Ceh <	ION REC 2-3 years of	UI	REM	ENTS Entire section HEIGHT	on below to	be completed by MD/DO/ WEIGHT		BM	1	B/P
DIABETES SCREEN Ethnic Minority YesC	ING (N	or require Signs of	D F Ins	OR DAY ulin Re	CARE) BMI>85% a sistance (hypertension, d						y History Yes O No O
							rs enrolled in licensed or pul	olic schoo	l operat	ed day c	are, preschool, nursery school
and/or kindergarten. (Ouestionnaire Admin		•			n Chicago or high risk lood Test Indicated?		☐ Blood Test Date			Resul	
									ection o		nditions, frequent travel to or born
in high prevalence countri	s or thos	e exposed to	adu	lts in hig	h-risk categories. See CD	DC guidelines	. http://www.cdc.gov/tb/pt	blications	/factsh	ecis/testi	ng/TB_testing.htm.
No test needed 🗆	Test p	erformed	u		dn Test: Date Read	1	/ / Result: Posit	ive LJ	Vegativ	1. 1	mm
				121	and Test Date Pana	arted /	/ Dognite Positi	VAIT N	Jacotiv	<u>а</u> П	Volne
LAB TESTS (Recomme	nded)	T	Date		ood Test: Date Repo		/ Result: Positi	ve 🗆 🗅	legativ	e 🛘 Date	Value Results
LAB TESTS (Recomme Hemoglobin or Hema		1	Date				/ Result: Positi				~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
			Date					ated)			~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Hemoglobin or Hema Urinalysis	tocrit	l Comme		3	Result		Sickle Cell (when indic	ated)		Date	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Hemoglobin or Hema Urinalysis	tocrit			3	Result		Sickle Cell (when indic	ated) ng Tool		Date	Results
Hemoglobin or Hema Urinalysis SYSTEM REVIEW	tocrit			3	Result		Sickle Cell (when indic Developmental Screeni	ated) ng Tool		Date	Results
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin	tocrit			3	Result		Sickle Cell (when indice Developmental Screening Endocrine	ated) ng Tool		Date	Results
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears	tocrit			3	Result up/Needs Scroening Result:		Sickle Cell (when indice Developmental Screening Endocrine Gastrointestinal	ated) ng Tool		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes	tocrit			3	Result up/Needs Scroening Result:		Sickle Cell (when indice Developmental Screening Endocrine Gastrointestinal Genito-Urinary	ated) ng Tool		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes	tocrit			3	Result up/Needs Scroening Result:		Sickle Cell (when indice Developmental Screential Endocrine Gastrointestinal Genito-Urinary Neurological	ated) ng Tool		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat	tocrit			3	Result up/Needs Scroening Result:		Sickle Cell (when indice Developmental Screening Endocrine Gastrointestinal Genito-Urinary Neurological Musculoskeletal	ated) ng Tool		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental	tocrit			3	Result up/Needs Scroening Result:	is	Sickle Cell (when indice Developmental Screening Developmental Screening Developmental Screening Developmental Screening Developmental Develop	ated) ng Tool		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN	Norma Asthma lication	1 Comme	nts/	Follow-	Result sp/Needs Screening Result: Screening Result:	is	Sickle Cell (when indice Developmental Screentian Endocrine Gastrointestinal Genito-Urinary Neurological Musculoskeletal Spinal Exam Nutritional status	ated) ng Tool		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN Respiratory Currently Prescribed D Quick-relief med	Norma Asthma lication ation (e.	Medication (e.g. Short	nts/	Follow-	Result sp/Needs Screening Result: Screening Result: Diagnosis of a Agonist) id)	is	Sickle Cell (when indice Developmental Screening Developmental Screening Developmental Screening Developmental Screening Developmental Develop	eated) ng Tool Normal		Date	Results ents/Follow-up/Needs
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN Respiratory Currently Prescribed □ Quick-relief mec □ Controller medic NEEDS/MODIFICA	Norma Asthma lication (s. FIONS	Medication (e.g. Short g. inhaled or required in t	nts/	Follow-	Result -up/Needs Sereening Result: Screening Result: Diagnosis of a Agonist) id)	f Asthma	Sickle Cell (when indice Developmental Screential Endocrine Gastrointestinal Genito-Urinary Neurological Musculoskeletal Spinal Exam Nutritional status Mental Health Other	eated) ng Tool Normal		Comm	Results ents/Follow-up/Needs LMP
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN Respiratory Currently Prescribed □ Quick-relief mec □ Controller medic NEEDS/MODIFICA	Asthma lication (e. FIONS	Medication (e.g. Short g. inhaled orequired in the state of the state	nts/	ing Bet icosterochool set	Result -ap/Needs Screening Result: Screening Result: Diagnosis of a Agonist) id) ting glasses, glass eye, chest particular the school should know	f Asthma	Sickle Cell (when indice Developmental Screenia Developmental Screenia Endocrine Gastrointestinal Genito-Urinary Neurological Musculoskeletal Spinal Exam Nutritional status Mental Health Other DIETARY Needs/Restrarrhythmia, pacemaker, prosthetiudent?	eated) ng Tool Normal	ental bri	Comm	Results ents/Follow-up/Needs LMP
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN Respiratory Currently Prescribed □ Quick-relief med □ Controller medican NEEDS/MODIFICA SPECIAL INSTRUCT MENTAL HEALTH If you would like to discue EMERGENCY ACT	Asthma lication (e. TIONS TIONS TOTHE as this str	Medication (e.g. Short g. inhaled or required in t	nts/ nts/ a: Act cort he se an h wi	Follow- ing Bet icostero chool sefety ything el th school	Result sup/Needs Seroening Result: Screening Result: Diagnosis of a Agonist) id) ting glasses, glass eye, chest get the school should know or school health personne	f Asthma protector for wabout this steel, cheak title	Sickle Cell (when indice Developmental Screenia Developmental Screenia Endocrine Gastrointestinal Genito-Urinary Neurological Musculoskeletal Spinal Exam Nutritional status Mental Health Other DIETARY Needs/Restrarrhythmia, pacemaker, prosthetiudent?	ictions c device, d	ental bri	Comm dge, false	Results ents/Follow-up/Needs LMP
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN Respiratory Currently Prescribed □ Quick-relief med □ Controller medican NEEDS/MODIFICA SPECIAL INSTRUCT MENTAL HEALTH If you would like to discue EMERGENCY ACT	Asthma lication eation (e. TIONS	Medication (e.g. Short g. inhaled or required in the describe of this day, I at the describe.	nts/ i: Act cort: he se an h win at sc	Follow- ing Bet icostero chool set g., safety ything el th school hool due	Result Screening Result: Screening Result: Screening Result: Diagnosis of a Agonist) id) fing r glasses, glass eye, chest part of the school should know or school health personner to child's health condition	f Asthma protector for wabout this steel, check title on (e.g., scizus	Sickle Cell (when indice Developmental Screential Radocrine Gastrointestinal Genito-Urinary Neurological Musculoskeletal Spinal Exam Nutritional status Mental Health Other DIETARY Needs/Restrarthythmia, pacemaker, prostheticulent? Nurse Teacher Teac	ictions c device, d Counse anut allerge	ental bri	Comm dge, false Principal mg proble xplanatio	Results ents/Follow-up/Needs LMP teeth, athletic support/cup m, diabetes, heart problem)?
Hemoglobin or Hema Urinalysis SYSTEM REVIEW Skin Ears Eyes Nose Throat Mouth/Dental Cardiovascular/HTN Respiratory Currently Prescribed Quick-relief medic Controller medic NEEDS/MODIFICA SPECIAL INSTRUC MENTAL HEALTH If you would like to discu EMERGENCY ACT Yes No I frye On the basis of the examin	Asthma lication eation (e. TIONS	Medication (e.g. Short g. inhaled or required in the describe of this day, I at the describe.	nts/ i: Act cort: he se an h win at sc	Follow- ing Bet icostero chool set g., safety ything el th school hool due	Result Screening Result: Screening Result: Screening Result: Diagnosis of a Agonist) id) fing r glasses, glass eye, chest plasses, glass eye, eye, eye, eye, eye, eye, eye, ey	f Asthma protector for a vabout this steel, check title on (e.g., scizus	Sickle Cell (when indice Developmental Screening Developmental Screening Developmental Screening Developmental Screening Developmental Screening Developmental Screening Developmental D	ictions c device, d Counse anut allerge	ental bri	Comm dge, false Principal mg proble xplanatio	Results ents/Follow-up/Needs LMP teeth, athletic support/cup m, diabetes, heart problem)?