Preventative Health Care Examination Form

IDENTIFYING INFORMATION

Student Name (last, first, middle) _____
ID Number: _____Date of Birth:_____

MEDICAL HISTORY

Seizures:_____
Chronic Illness:_____
Allergies:_____
Drug Allergies:_____
Medications:_____
Significant Historical Information:_____
_____

PHYSICAL EXAM:

N	Abn			
____	____	General Appearance	Hgt:_____ Wgt:_____	BP:_____/_____
____	____	HEENT	Hearing: R_____ L_____	
____	____	Skin	Vision: R_____/_____ L_____/_____	
____	____	Neck	Optional:	
____	____	Chest	HCT/HGB:_____ UA:_____	
____	____	Heart		
____	____	Abd-Genitalia		
____	____	Extremities-Back (including scoliosis for 6th grade)		
____	____	Neuro		

Explain Abnormal Exam: _____
_____

RECOMMENDATIONS:

____ No restrictions – normal exam
____ Restrictions and suggestions to school: _____
_____
_____

_____
Signature *(Physician/APRN/PA/EPSDT Provider)* Date
Address: _____Telephone: _____

Mail completed form to: Student Health Services, Kentucky State University, 400 East Main St., Frankfort, KY 40601 or Fax to: (502) 597-6565/Scan to: Samantha.Todd@kysu.edu

(Rev 6/18)