Ecole Chrétienne des Fréres Unis

Christian School of United Brothers

STUDENT HEALTH RECORD

Nom De Famille: _____ **Prenom**: _____ **Date De Naissance: (J/M/A)** _____

Sexe: H/ H/F **Paran (pou timoun) oswa yon kontak ijans** _____

Parent or emergency contact

Adres _____ **Telefòn** _____

HX *(Circle)* DM Seizures Asthma Anemia Other: **Vaccinations:** TDap Hep A/B Polio MMR Pentavac BHG

COMPREHENSIVE PHYSICAL EXAM *1 = Normal 2 = Refer for additional evaluation 3 = Immedicate care needed*

Date _____

B/P _____

Height: _____

Weight: _____

Muac R / Y / G

HEENT □ □ □ Neurological □ □ □ Skin □ □ □ Lungs □ □ □ Abdomen □ □ □ Genital □ □ □

Heart □ □ □ Extremities □ □ □ Urinary □ □ □ Vision □ □ □ Hearing □ □ □ Dental □ □ □

Emotional/Social □ □ □ Language/Communication □ □ □ Fine/Gross Motor Skills □ □ □

Notes: _____

Follow-up: Date _____ Results/Notes _____

Date _____

B/P _____

Height: _____

Weight: _____

Muac R / Y / G

HEENT □ □ □ Neurological □ □ □ Skin □ □ □ Lungs □ □ □ Abdomen □ □ □ Genital □ □ □

Heart □ □ □ Extremities □ □ □ Urinary □ □ □ Vision □ □ □ Hearing □ □ □ Dental/Oral □ □ □

Emotional/Social □ □ □ Language/Communication □ □ □ Fine/Gross Motor Skills □ □ □

Notes: _____

Follow-up: Date _____ Results/Notes _____

Date _____

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Muac R / Y / G

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Heart □ □ □ Extremities □ □ □ Urinary □ □ □ Vision □ □ □ Hearing □ □ □ Dental □ □ □

Emotional/Social □ □ □ Language/Communication □ □ □ Fine/Gross Motor Skills □ □ □

Notes: _____

Follow-up: Date _____ Results/Notes _____