



The Abraham Joshua Heschel School
Miriam & Isaac Blech Early Childhood Center
Henry Lindenbaum Lower School
 270 West 89th Street, New York, NY 10024
The Joseph Slifka Middle School
 314 West 91st Street, New York, NY 10024
The Abraham Joshua Heschel High School
The Joseph and Sylvia Slifka Building
 20 West End Avenue, New York, NY, 10023

**MUST BE SIGNED BY
 PHYSICIAN
 ONE FORM PER
 CHILD**

**PERSONAL HEALTH HISTORY
 2010-2011**

BOTH SIDES TO BE COMPLETED BY PHYSICIAN

Student _____ DOB _____ Entering Grade _____

Home Phone: _____

Parent #1/Guardian: _____ Work or Cell Phone: _____

Parent #2/Guardian: _____ Work or Cell Phone: _____

INSURANCE CO. & POLICY #: _____

To be completed by Health Practitioner: Date Exam Performed: _____

Height _____ % _____ Weight: _____ % _____

Pulse: _____ Resp. _____ B.P. _____ / _____

Check each line	Normal	Abnormal	Follow-Up	Omitted
General				
Skin/Scalp				
HEENT				
Neck				
Lungs				
Heart				
Abdomen				
Musculoskeletal-Scoliosis				
Neurological				
Endocrine				
Genitalia/Tanner Stage				
Psychosocial				
Nutrition				
Dental				

IMMUNIZATION HISTORY:

Dose	1	2	3	4	5	6
DPT	*	*	*			
DPT/HIB						
DtaP						
DT/Td	Booster every ten years					
OPV	*	*	*			
IPV						
MMR	*			TWO measles required if born		
Measles	*	*		Jan. 1, 85 & after		
Mumps	*					
Rubella	*					
HIB						
Hep. B	*	*	*	Required		
Varicella	Had Chickenpox Disease: Yes/No					

*Minimum requirement prior to attendance

Allergies:

Epi-Pen Prescribed: Yes No Dosage: _____

Asthma: Yes No Active Resolved

Age of onset: _____ Last Episode (year): _____ Peak Flow: _____

Asthma Medications:

PPD Mantoux: required
 for any student new to
 NYC schools

Date	Results/M	X-Ray

Hematocrit/
 Hemoglobin

Date	HCT	HGB

Vision Screening

Date	Right	Left

Auditory Screening

Date		
Right	Pass <input type="checkbox"/>	Fail <input type="checkbox"/>
Left	Pass <input type="checkbox"/>	Fail <input type="checkbox"/>

History of Illness/Surgery/Medication:

Restrictions/Instructions:

Cleared to participate in gym and sports (note any restrictions above). Yes No

Name and Title of Physician (please print): _____

Physician 's Signature: _____ Date: _____

Stamp/Print:

Name

Address

Phone