Student's Name Last Nawaz First Ayesha Middle	Birth Date 12/21/19 Month/Day/ Year	Sex	School	Grade Level/ ID #

HEALTH HISTORY TO BE COMPLETED AND SIGNEDBY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma?	Yes (No)	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes (No)	
Child wakes during the night coughing	Yes (No)				
Birth defects?	Yes (No)		Hospitalizations? When? What for?	Yes (No)	
Developmental delay?	(Yes) No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes (No)		Surgery? (List all.) When? What for?	Yes (No)	
Diabetes?	Yes (No)		Serious injury or illness?	Yes (No)	
Head injury/Concussion/Passed out?	Yes (No)		TB skin test positive (past/present)?	Yes* (No)	*If yes, refer to local health department.
Seizures? What are they like?	Yes (No)		TB disease (past or present)?	Yes* (No)	
Heart problem/Shortness of breath?	Yes (No)		Tobacco use (type, frequency)?	Yes (No)	
Heart murmur/High blood pressure?	Yes (No)		Alcohol/Drug use?	Yes (No)	
Dizziness or chest pain with exercise?	Yes (No)		Family history of sudden death before age 50? (Cause?)	Yes (No)	
Eye/Vision problems? Glasses ☹ Contacts ☹ Last exam by eye doctor Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☹Braces ☹Bridge ☹Plate Other Other concerns?		
Ear/Hearing problems?	Yes (No)		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature Date		
Bone/Joint problem/injury/scoliosis?	Yes (No)				

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT 2'8" WEIGHT 21 lb BMI 14 B/P 84/48

DIABETES SCREENING BMI>85% age/sex Yes ☹ (No) ☹ And any two of the following: **Family History** Yes ☹ (No) ☹ **Ethnic Minority** (Yes) ☹ No ☹
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☹ (No) ☹ **At Risk** Yes ☹ (No) ☹

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Blood Test Indicated? (Yes) No **Blood Test Date** 9/7/21 **Blood Test Result** 2 (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *	7/5/22	12.1	Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	/		Endocrine	/	
Ears	/		Gastrointestinal	/	
Eyes Normal Yes☹ No☹ Objective screening Yes☹ No☹ Result ____ Amblyopia Yes☹ No☹ Referred to Opthalmologist/Optometrist Yes☹ No☹	/		Genito-Urinary	/	LMP
			Neurological	/	
Nose	/		Musculoskeletal	/	
Throat	/		Spinal examination	/	
Mouth/Dental	/		Nutritional status	/	
Cardiovascular/HTN	/		Mental Health	/	
Respiratory	/				

NEEDS/MODIFICATIONS required in the school setting: expressive speech delay

DIETARY Needs/Restrictions: none

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup: none

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☹ Nurse ☹ Teacher ☹ Counselor ☹ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☹ (No) ☹ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION (Yes) No **Modified** **INTERSCHOLASTIC SPORTS** (for one year) (Yes) No **Limited**

Physician/Advanced Practice Nurse/Physician Assistant performing examination
Print Name Mama Angelora **Signature** **Date** 3/20/23

Address 3720 Market St Camp Hill PA **Phone** 717 909 4670

www.alhudapa.org (Complete both sides)

Al-HUDA SCHOOL
1007 Rana Villa Ave, Camp Hill PA 17011

Please Print

CHILD HEALTH EXAMINATION

Student's Name	Birth Date	Sex	School	Grade Level /ID#
Last Nawaz First Ayesha Middle	12/21/2019 Month/Day/ Year	f		

Address Street City ZIP code | Parent/ Guardian | Telephone # Home Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	⊖PCV7 ⊖PPV23	⊖PCV7 ⊖PPV23	⊖PCV7 ⊖PPV23	⊖PCV7 ⊖PPV23	⊖PCV7 ⊖PPV23	⊖PCV7 ⊖PPV23
Check specific type (PCV7, PPV23)						
Other (Specify hepatitis A, meningococcal, etc.)						

See attached Sheet

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature Title MD Date 3/20/23

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) Title Date

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) Title Date

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. **Laboratory confirmation (check one)** ⊖ Measles ⊖ Mumps ⊖ Rubella ⊖ **Hepatitis B** ⊖ Varicella
Lab Results **Date** MO DA YR **(Attach copy of lab report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																						
Age/Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/ Contacts

(Complete Both Sides)

Immunization Summary

Ayesha Nawaz
MRN: **933765634**

UPMC CCP - Heritage, Camp Hill Office
3720 Market St
Camp Hill PA 17011-4325

Patient Information

Patient Name	Legal Sex	DOB
Nawaz, Ayesha	Female	12/21/2019

Immunizations

NAWAZ,AYESHA

DTaP / Hep B / IPV

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
2/21/2020	SKB	934NJ	IM/RVL	Craig A Shrift, MD	
4/22/2020	SKB	JK473	IM/RT	Andrea L Burks, DO	
6/22/2020	SKB	23YL4	IM/RT	Craig A Shrift, MD	

DTaP / HiB / IPV

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
6/21/2021					

Hep A, 2 Dose

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
12/22/2020	SKB	5575N	IM/RT	Craig A Shrift, MD	
9/17/2021	SKB	2K57N	IM/RT	Kathleen M Zimmerman, MD	

Hep A, Unspecified

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
12/22/2020	SKB	5575N	/RT		
9/17/2021	SKB	2K57N	/RT		

Hep B, Adolescent or Pediatric

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
12/21/2019		R031056			

Hib (PRP-T)

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
2/21/2020	PMC	UJ143AA	IM/LVL	Craig A Shrift, MD	
4/22/2020	PMC	UJ327AA	IM/LT	Andrea L Burks, DO	
6/22/2020	PMC	UJ328AD	IM/LT	Craig A Shrift, MD	

Influenza (IM) Preservative Free

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
9/23/2020	PMC	99J23	IM/LD	Craig A Shrift, MD	
12/22/2020	PMC	94H24	IM/LT	Craig A Shrift, MD	

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
9/17/2021	PMC	33D9L	IM/LT	Kathleen M Zimmerman, MD	
12/29/2022	PMC	3AH4A	IM/LT	Maria S Angelova, MD	

Influenza, Unspecified

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
12/22/2020	PMC	94H24	/LT		
9/17/2021	PMC	33D9L	/LT		

MMR

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
12/22/2020	MERCK SHAR	S039311	SQ/RT	Craig A Shrift, MD	

PNEUMOCOCCAL CONJUGATE 13-VALENT

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
2/21/2020	WA	AW7402	IM/LVL	Craig A Shrift, MD	
4/22/2020	WA	CM1131	IM/LT	Andrea L Burks, DO	
6/22/2020	WA	CW5295	IM/LT	Craig A Shrift, MD	
12/29/2022	PFR	FW0032	IM/LT	Maria S Angelova, MD	

Rotavirus Pentavalent

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
2/21/2020	MERCK SHAR	R035371	PO/ORAL	Craig A Shrift, MD	
4/22/2020	MERCK SHAR	1660937	PO/ORAL	Andrea L Burks, DO	
6/22/2020	MERCK SHAR	1660942	PO/ORAL	Craig A Shrift, MD	

Varicella

Date	Manufacturer	Lot#	Route/Site	Ordering Provider	INCD
12/22/2020	MERCK SHAR	T012550	SQ/LT	Craig A Shrift, MD	