



Υπουργείο Παιδείας  
και Θρησκευμάτων  
Υπουργείο Υγείας

**PERSONAL STUDENT HEALTH REPORT**  
(On implementation of the law 4229/2014, article 11, par.2)

FULL NAME (IN CAPITALS): .....

DATE OF BIRTH: .....

CONTACT NUMBER OF THE FAMILY: .....

SCHOOL: ..... CLASS: .....

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**The Personal Student Health Report (PSHR) is kept in School and a copy is maintained in the Health Booklet of the Child. The content of the PSHR is confidential.**

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It is filled in upon a preventative medical examination which includes the medical history and physical examination, according to the medical examination Sheet for the Personal Student Health Report. A further special check is done only if there are special medical indications. On the PSHR, the findings of the examination that regard the school are noted. In case of a change in the situation of the health of the child the PSHR is updated under the responsibility of the parents/legal guardians.

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**INFORMATION FOR THE SCHOOL**

*(Is noted in order to support the child in School and with the final decision of the doctor, upon consultation with the parent/guardian or and the child. Information that could put the child at risk should by no means be omitted.)*

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**EVALUATION**

**FOR THE PARTICIPATION IN PHYSICAL EDUCATION, ATHLETICS AND OTHER SCHOOL ACTIVITIES\***

- Participation with no limitations (Examination shows no reason for limitations)
- Participation with limitations (Due to health issues)
- Health issues and limitations:
  
- Reference for a special check\*\* (From the remaining systems there are no findings that require limitations in the participation of school activities)
- Specialty/ies where the reference is made:

Examination Date:

Doctor's signature & stamp:

Health Unit Stamp  
(for doctors of Health Care/  
National Primary Health Care Network)

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**EVALUATION UPON SPECIAL CHECK\*\***

**FOR THE PARTICIPATION IN PHYSICAL EDUCATION, ATHLETICS AND OTHER SCHOOL ACTIVITIES\***

- Participation with no limitations (Examination shows no reason for limitations)
- Participation with limitations (Due to health issues)
- Health issues and limitations:

➤ Medical specialty:

➤ Check that was done:

Examination Date:

Doctor's signature & stamp:

Health Unit Stamp  
(for doctors of Health Care/  
National Primary Health Care Network)

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**\*This evaluation does not apply to the Panhellenic School Races and the Panhellenic School Championships, and doesn't apply also to school activities that are fulfilled by entities other than the School or the Ministry of Education and Religious Affairs.**

**\*\*Regards the special check which, according to the judgement of the doctor that conducted the examination, is necessary to evaluate for the participation in school activities. In those cases, a referential note is given with the description of reasons.**

*Scientific Edit: Institute of Child Health, Division of Social and Developmental Pediatrics, National School of Public Health, Department of Child Health*

**STUDENT HEALTH FORM PAGE**  
(Kept at the doctor's or health service's records)

Student's last name          Student's first name          Date of birth          Sex – M/F          Insurance Number  
**MEDICAL HISTORY** (To be completed and signed by parent/guardian). If required, it can be completed by the doctor)

Medical history: general questions		YES	NO		Family history: heart problems	YES	NO
1	Has or had any serious disease			13	Has someone in the family experienced a fainting episode or seizures of unexplained reason?		
2	Have you ever spent the night in the hospital?			14	Has someone in the family hypertrophic or dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy, Marfan syndrome, Naxos disease, long QT syndrome, short QT syndrome, Brugada syndrome		
3	Surgery				<b>Student history: additional information</b>		
4	Medications and frequency			15	Spasms episode		
5	Allergies (food, medicine, other)			16	Coughing, wheezing, breathing difficulty while exercising?		
	<b>Medical history: Heart problems</b>			17	Have you ever had an injury to a bone, muscle, ligament, or tendon, arthritis?		
6	Diagnosed with heart disease or hypertension			18	Do you think your child has vision problems?		
7	Have you ever passed out or nearly passed out DURING or AFTER exercise without an apparent reason?			19	Do you think your child has hearing problems?		
8	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			20	Do you worry about its weight or nutrition?		
9	Panting or getting tired while exercising, more than other children of same age?			21	Do you or the school worry about its development (speech, movement, learning skills)?		
10	Does your heart ever race or skip beats (irregular beats) during exercise?			22	Do you or the school worry about its mood or behavior (sadness, sociability, aggressiveness, anger, hyperactivity, bladder and bowel control)?		
	<b>Family history: heart problems</b>			23	Is there anything else you would like to discuss about?		
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?						
12	Has someone in the family had a heart attack or coronary disease or stroke in young or middle age? (<55 for men and <65 for women)						
<b>Additional information on the questions answered with YES:</b>							

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Last name of parent/legal guardian          Relationship to the child          Date          Signature          Contact telephone number  
**PHYSICAL EXAMINATION (To be completed by the doctor)**

Examination				
Weight:	kg	Height:	m	Body Mass Index:
				Pulse: /min
				BP: mmHg
Medical examination		Normal	Abnormal findings	
1	Appearance, skin, Marfan stigmata			
2	Visual acuity, strabismus			
3	Oral cavity, teeth			
4	Heart (murmurs, tones, pulses), femoral			
5	Respiratory system			
6	Abdomen, liver/spleen, genital organs			
7	Nervous and musculoskeletal system, scoliosis			
8	Other findings			

**Additional information about history or physical examination – conclusions (To be completed by the doctor)**

	Permission for participation in school activities: <input type="checkbox"/> without restrictions <input type="checkbox"/> with restrictions <input type="checkbox"/> referral →specialties
<b>Proof of Immunization:</b> YES      NO	Comments:

Doctor's full name

Date

Doctor's signature / Seal→

Health Institution for children, Direction of Social and Developmental Paediatrics, National School of Public Health, Health division for children.