

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____ School Year 2010-2011

IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached
- No immunizations given today
- Immunizations given since last Health Appraisal:
- Sickle Cell Screen: Positive Negative Not done Date: _____
- PPD: Positive Negative Not done Date: _____
- Elevated Lead: Yes No Not done Date: _____
- Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: _____

- Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
- Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Date of Exam: _____

Referral

Body Mass Index: _____ . _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormal findings : _____

MEDICATIONS

Medications (list all): None

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, play ground, work & school activities OR only as checked:

- ___ **Contact:** cheerlead, ski, volleyball, handball, fence, baseball, hockey, softball, football, basketball, soccer and wrestling.
- ___ **Non-contact:** badminton, bowl, golf, swim, table tennis, tennis, archery, gymnastics, weight train, dance, cross country, track/field, run and walk.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension Other: _____

By signing this form, I consent to my child's physical exam and for the release of medical information to the school and/or the health care provider.

Parent/Guardian Signature _____ Date: _____

Provider's Signature: _____ Date: _____

Provider's Name: _____

Address: _____

For Office Use ONLY:

School Physician's Signature Date

HEALTH HISTORY

Child's Name: _____ Age: _____ Birth date: _____

Address: _____ Phone Number: _____

Name of Family Physician or Provider: _____

To be completed by parent/guardian:

Health History during last 12 months:

- | | | |
|---|------------------------------|-----------------------------|
| Does this child have an ongoing health concern? (asthma, diabetes, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have any chronic illnesses or conditions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have any allergies to medication, food or environmental? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the allergy require emergency treatment, such as EPI-PEN? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have problems with blood pressure, heart, or heart murmur? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there a history of any hospitalizations, significant injuries, or surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any dizziness, fainting, convulsions, seizures, or headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have any problems with liver, spleen, kidneys, etc.? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are there any CURRENT medical concerns/injuries? See below Yes No

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Head/concussion _____ | <input type="checkbox"/> Glasses/contacts _____ | <input type="checkbox"/> Eyes _____ | <input type="checkbox"/> Ears _____ |
| <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Throat _____ | <input type="checkbox"/> Nose /Nose bleeds _____ | |
| <input type="checkbox"/> Chest _____ | <input type="checkbox"/> Respiratory _____ | <input type="checkbox"/> Cough _____ | <input type="checkbox"/> Neck _____ |
| <input type="checkbox"/> Cardiovascular _____ | <input type="checkbox"/> Gastrointestinal _____ | <input type="checkbox"/> Heat exhaustion/stroke _____ | |
| <input type="checkbox"/> Genitourinary _____ | <input type="checkbox"/> Neurological _____ | <input type="checkbox"/> Skin disease _____ | |
| <input type="checkbox"/> Musculoskeletal (include any fractures, etc.) _____ | | | |
| <input type="checkbox"/> Hernia _____ | <input type="checkbox"/> Teeth _____ | <input type="checkbox"/> Dental appliances _____ | |

Does this child take any medication regularly at home? Yes No

Require medication at school? Yes No

Is this child on any special diet or food restrictions? Yes No

Describe child's nutritional pattern and dietary intake: _____

List any significant medical concerns or sudden death of family members:

- Mother _____ Father _____ Grandparents _____
 Siblings _____ Other _____

Please describe any YES responses:

The above information is current and correct to the best of my knowledge.

By signing this form, I consent to my child's physical exam and for the release of medical information to the school and/or the health care provider.

Parent/Guardian Signature: _____ Date: _____

Please be sure to COMPLETE the HEALTH HISTORY and SIGN BOTH SIDES of this form.