

PHYSICAL EXAMINATION & HEALTH HISTORY FORM

The following information is requested so the school and parent can work together to meet the physical, intellectual, and emotional needs of the child.

Child's Health History Date: _____ Grade: _____ Date of Birth: _____

Child's Name: _____

Address: _____

City _____ State _____ Zip: _____

Child's Physician: _____

Physician's Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

PAST ILLNESS- please check all illnesses your child has had

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Polio | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Frequent Colds |

1- Please specify any other serious illness, operation or injury, and age when occurred:

2- Has your child been exposed to tuberculosis? Yes No If so, Year _____

GENERAL HEALTH-

1- Does your child have any condition or illness that you feel the school should know about? Yes
 No If Yes please explain:

2- Does your child wear glasses or corrective lenses? Yes No If yes, last exam date _____

3- Does your child have hearing difficulties? Yes No If yes, last exam date _____

4- Does your child have any allergies? Yes No If yes, what are they and how are they treated?

5- Is there any special medical need you'd like the school to assist your child with during the school year?
If yes, please specify:

Parent/Guardian Signature: _____

EXAMINATION RECORD TO BE FILLED OUT BY THE PHYSICIAN

General Appearance		General nutrition	
Blood pressure:		Hearing (audiometric)	
Tonsils & adenoids:		Other lab exam:	
Height		Weight	
Posture:		Feet:	
Skin		Heart:	
Abdomen		Hernia	
Genitals:		Pulse:	
Vision (right eye)		Vision (left eye)	
Thyroid:		Other glands:	
Reflexes:		Lungs:	
Emotional status			
General Condition			

1- Is the student capable of carrying a full program of school works, including Physical Education?
 Yes No. If no, please give reason and state limitation _____

2- Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other? Yes No If yes explain _____

3- Is the student's immunizations up to date? Yes No

(Child's Name) _____ has been examined by me and found free of disease and is physically and mentally able to participate in group activities.

Physician's Signature _____ Date: _____