

Part A : STUDENT HEALTH HISTORY

(To be completed by parent/guardian and reviewed by a licensed examining provider.)

Student's Name _____ **Grade** _____ **Birth Date** _____

Sex: • Male • Female

DISEASE HISTORY	TYPE/ YEAR	DISEASE HISTORY	TYPE/YEAR
Food Allergies * include Allergy care plan		Mononucleosis	
Non-Food, non-drug allergies (ie.bee sting)		Neuromuscular Disorder	
Asthma * include Asthma plan		Chronic Otitis Media	
Bowel Control Issues		Kidney or Bladder Condition	
Congenital Disorder		Autoimmune Disorder	
Convulsive Disorder * include Seizure plan		Strep Infections	
Diabetes * include Diabetes mgmt plan		Juvenile Rheumatoid Arthritis	
Eating Difficulties		Physical Disability	
Influenza		Autism Spectrum Disorder	
Other * include Other special health need plan		Hematological Disorder	
Drug Allergies		ADD/ADHD	
Heart Disease * include Other special health needs plan		Concussion/TBI	
Chicken Pox		Vision Disorder	
Hepatitis		Corrective Lenses	
Lyme Disease		Hearing Disorder	
		Hearing Assist Device	

OPERATION / INJURIES/ Hospitalizations(PLEASE SPECIFY): _____

ADDITIONAL COMMENTS: _____

Medications: Name, Dose, Route, Time **Given @ school? _____

****Kindly provide Authorization to Administer Rx/ OTC medication form if medication is required during school hours.**

ALLERGIES (Drug/Environmental/Food): _____

Student Requires Epinephrine: ____ Yes ____ No * The Allergy forms and 2 epinephrine pens are needed for school.

Student Requires Rescue Inhaler: ____ Yes ____ No * Asthma Action plan and an inhaler are needed for school. Please consider allowing 5th through 8th grade students to self-administer for sports and class trips.

Part B : Physical Examination

(To be completed by licensed examining provider OR attach examiner's own form)

Student's Name: _____ **Exam Date:** _____

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:
	Normal Exam	Abnormal Findings:	
Head			
Eyes			
Ears			
Nose			
Throat			
Lymph Glands			
Heart			
Lungs			
Abdomen			
Hernia			
Genitalia			
Skin			
Orthopedic			
Scoliosis			
Neurological			
Speech			
Nutrition			

Physician's Comments and Recommendations: _____

Any Limitation of Activity? : • No • Yes (Please define): _____

If the student requires medications at school such as epinephrine, asthma inhalers, or other medications please complete the appropriate medication forms.

Please attach a copy of the student's immunization records.

Physician's signature: _____ **Date:** _____

Physician's Name, Address and Telephone #:

Office Stamp
