

Student's Name			Birth Date		Sex	School	Grade Level/ID #
Last	First	Middle	Month/Day/Year				

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY 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		Hospitalizations? When? What for?	Yes	No	
Birth defects?	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Developmental delay?	Yes	No		Serious injury or illness?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Diabetes?	Yes	No		TB disease (past or present)?	Yes*	No	
Head injury/Concussion/Passed out?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Seizures? What are they like?	Yes	No		Alcohol/Drug use?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Dizziness or chest pain with exercise?	Yes	No		Other concerns?			
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor				Information may be shared with appropriate personnel for health and educational purposes.			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Parent/Guardian Signature	Date		
Ear/Hearing problems?	Yes	No					
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	WEIGHT	BMI	B/P
DIABETES SCREENING BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>	Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>			

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 _____ Blood Test Result _____ (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 *			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 <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>			Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	

NEEDS/MODIFICATIONS required in the school setting _____ **DIETARY** Needs/Restrictions _____

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup _____

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 **PHYSICAL EDUCATION** Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited (If No or Modified, please attach explanation.)

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name _____ Signature _____ Date _____

Address _____ Phone _____