

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			Yes	No
Birth defects?	Yes	No		Hospitalizations?	Yes	No
Developmental delay?	Yes	No		When? What for?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.)	Yes	No
Diabetes?	Yes	No		When? What for?	Yes	No
Head injury/Concussion/Passed out?	Yes	No		Serious injury or illness?	Yes	No
Seizures? What are they like?	Yes	No		TB skin test positive (past/present)?	Yes*	No
Heart problem/Shortness of breath?	Yes	No		TB disease (past or present)?	Yes*	No
Heart murmur/high blood pressure?	Yes	No		Tobacco use (type, frequency)?	Yes	No
Dizziness or chest pain with exercise?	Yes	No		Alcohol/Drug use?	Yes	No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Family history of sudden death before age 50? (Cause?)	Yes	No
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		
Ear/Hearing problems?	Yes	No		Other concerns?		
Bone/Joint problem/injury/scoliosis?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.		
				Parent/Guardian Signature	Date	

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 *				
Urinalysis			Sickle Cell * (as indicated)	
			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/Optomtrist 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 _____ (If No or Modified, please attach explanation.)
PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS (for one year)** Yes No Limited

Physician/Advanced Practice Nurse/Physician Assistant performing examination _____

Print Name	Signature	Date
Address	Phone	

(Complete both sides)