Health Information and Physical Exam Form for: NEW students entering Early Childhood to 8th grade And ALL Kindergarten, 4th, and 7th grade students.

Student: _____ Date of Birth: _____ Grade: _____

Health History - to be completed by parent/guardian

History/Medical Diagnoses – Check any that apply:

☐ Asthma ☐ ADHD ☐ Chicken Pox ☐ Diabetes ☐ Epilepsy ☐ Heart/Lung

☐ Hearing ☐ Glasses/Contacts ☐ Surgery:_____

☐ Allergies - Medication:_____ ☐ Allergies - Food:_____

☐ Other Health Concerns:_____

Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, will need additional health care plans. Please contact the school nurse to complete this information.

Orthopedic History – Check any that apply:

☐ Head Injury ☐ Leg/foot Injury ☐ Back/Neck Injury Explain:_____

Physician's name:_____ Phone Number:_____

Dentist's name:_____ Phone Number:_____

To ensure safe care of my child, I agree that pertinent health information may be shared with appropriate school staff. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and address in case of an emergency. The school nurse may contact the health care provider regarding any health concerns pertaining to students. I understand that basic first aid and emergency care will be provided as needed by school staff. I understand an update immunization record must be on file with the school prior to first day attendance.

Signature of Parent/Guardian:_____ **Date:**_____

Physical Examination – to be completed by Physician

Date of Exam:_____ Height:_____ Weight:_____ B/P:_____/_____

Pulse:_____ Eyes: R:_____ L:_____ Hearing:_____

History/Medical Diagnoses – Check any that apply: **IMMUNIZATION RECORD must be attached**

☐ Chronic Condition/Major Surgeries:_____

☐ Allergies (list):_____ ☐ Medications (list):_____

☐ Special Seating Recommendation:_____ ☐ Scoliosis: _____

☐ Medications to be taken at school (list):_____

ORTHOPEDIC EXAM (for PE/sports participation)

ROM Back Neck Shoulders Lower Extremities Upper Extremities

If not, explain:_____

☐ Full Participation ☐ Limited(explain):_____ ☐ None

Physician's name:_____ Phone Number:_____

Address:_____

Signature of Physician:_____ **Date:**_____