



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

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (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
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 Other		
Dizziness or chest pain with exercise?	Yes	No		Other concerns?		
Eye/Vision problems? _____ 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)				<b>Parent/Guardian Signature</b>	<b>Date</b>	
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  No  And any two of the following: **Family History** Yes  No  **Ethnic Minority** Yes  No   
**Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes  No  **At Risk** Yes  No

**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**

<b>LAB TESTS</b> *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results	Date	Results
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)
Urinalysis				Other

<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Result	LMP
Nose			Genito-Urinary	
Throat			Neurological	
Mouth/Dental			Musculoskeletal	
Cardiovascular/HTN			Spinal examination	
Respiratory			Nutritional status	
			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**

(Complete both sides)