

STUDENT HEALTH AND PHYSICAL EXAM FORM

HEALTH HISTORY (to be filled out by PARENT/GUARDIAN)

Student's Name: _____ Birth Date: _____ Sex ____ M ____ F

Grade: _____ Languages Spoken at home: _____

Parent / Guardian Name: _____

HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers:

Operations or Serious Hospitalizations:

Current Medications (Name, Dose, Frequency and Reason used):

Allergies: (Name, reaction to exposure)

Drug: _____

Food: _____

Environmental: _____

Any Other Additional comments or information that you would like to provide:

Student's Name: _____

Exam Date: _____

PHYSICAL EXAM

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			

Physical Exam Comments:

Any Limitation of Activity or other Recommendations? No Yes (Please define):

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.
2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: _____ Date: _____

Name and Address Stamp: