Part A : STUDENT HEALTH HISTORY

(To be completed by parent/guardian and reviewed by a licensed examining provider.)

Student's Name_____**Grade**_____ **Birth Date**_____

Sex: • **Male** • **Female**

DISEASE HISTORY	TYPE/ YEAR	DISEASE HISTORY	TYPE/YEAR
Food Allergies ***include Allergy care plan**		Mononucleosis	
Non-Food, non-drug allergies (ie.bee sting)		Neuromuscular Disorder	
Asthma * **include Asthma plan**		Chronic Otitis Media	
Bowel Control Issues		Kidney or Bladder Condition	
Congenital Disorder		Autoimmune Disorder	
Convulsive Disorder ***include Seizure plan**		Strep Infections	
Diabetes * **include Diabetes mgmt plan**		Juvenile Rheumatoid Arthritis	
Eating Difficulties		Physical Disability	
Influenza		Autism Spectrum Disorder	
Other * **include Other special health need plan**		Hematological Disorder	
Drug Allergies		ADD/ADHD	
Heart Disease * **include Other special health needs plan**		Concussion/TBI	
Chicken Pox		Vision Disorder	
Hepatitis		Corrective Lenses	
Lyme Disease		Hearing Disorder	
		Hearing Assist Device	

OPERATION / INJURIES/ Hospitalizations(PLEASE SPECIFY):_____

_____

_____

ADDITIONAL COMMENTS:_____

_____

Medications: Name, Dose, Route, Time **Given @ school?_____

_____

_____

****Kindly provide Authorization to Administer Rx/ OTC medication form if medication is required during school hours.**

ALLERGIES (Drug/Environmental/Food):

_____

Student Requires Epinephrine: ____Yes ____ No * The Allergy forms and 2 epinephrine pens are needed for school.

Student Requires Rescue Inhaler:____ Yes ____ No * Asthma Action plan and an inhaler are needed for school.

Part B : Physical Examination

(To be completed by licensed examining provider OR attach examiner's own form)

Student's Name:_____ **Exam Date:**_____

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		

Physician's Comments and Recommendations: _____

_____

_____

Any Limitation of Activity? : • No • Yes (Please define):_____

_____

If the student requires medications at school such as epinephrine,asthma inhalers,or other medications please complete the appropriate medication forms.

Please attach a copy of the student's immunization records.

Physician's signature:_____ **Date:**_____

Physician's Name, Address and Telephone #: **Office Stamp**

_____

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