

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? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes No
Developmental delay?	Yes	No			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes No
Diabetes?	Yes	No		Serious injury or illness?	Yes No
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes* No
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes* No
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes No
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes No
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ 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		Information may be shared with appropriate personnel for health and educational purposes.	
Bone/Joint problem/injury/scoliosis?	Yes	No		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 <input type="checkbox"/> No <input type="checkbox"/>			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 *				Sickle Cell * (as indicated)				
Urinalysis				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 _____	Genito-Urinary		LMP	
	Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Referred to Ophthalmologist/Optometrist	Yes <input type="checkbox"/> No <input type="checkbox"/>		Neurological			
Nose					Musculoskeletal			
Throat					Spinal examination			
Mouth/Dental					Nutritional status			
Cardiovascular/HTN					Mental Health			
Respiratory								
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>					
Physician/Advanced Practice Nurse/Physician Assistant performing examination								
Print Name			Signature			Date		
Address					Phone			

(Complete both sides)