NEW 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			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:

____
____
____

Please attach updated immunization records.

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		

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:

Please attach updated immunization records.