This form may be completed by a Parent/ Guardian

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.

This form must be completed by a physician, physician's assistant, or advanced practicing nurse.

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'S SIGNATURE: _____ Date: _____

Name and Address Stamp:

Please attach updated immunization records.