Kindergarten – 5th Grade
PHYSICAL EXAM / HEALTH HISTORY
To be completed by your child's health care provider.

Name_________________________________Sex______Birth Date_________________
Address____Telephone_________________
Father's Name__________________________Mother's Name_______________________

TYPE of VACCINE	1st DOSE MM/DD/YY	2nd DOSE MM/DD/YY	3rd DOSE MM/DD/YY	4th DOSE MM/DD/YY	5th DOSE MM/DD/YY
Diphtheria, Tetanus, Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT)-for under 7 yrs					
Tetanus and Diphtheria (Td, Tdap)-for 7 yrs and older					
Polio (IPV, OPV)					
MMR (Measles, Mumps, Rubella) (minimum age: on or after 1st birthday)					
Hepatitis B (Hep B)					
Varicella (chickenpox)					
HIB (Haemophilus Influenza b)					
Other (specify)					

HEALTH HISTORY

Communicable Diseases
- ☐ German Measles ____________ (month & year)
- ☐ Mumps _ _________________ (month & year)
- ☐ Red Measles________________ (month & year)
- ☐ Chickenpox ________________ (month & year)

Identified Health Conditions
- ☐ ADHD / ADD / other learning disability ____
- ☐ Allergies (describe) ____
- ☐ Asthma or other breathing problems (describe) ____
- ☐ Bladder problems / Bowel problems (describe) ____
- ☐ Diabetes: ☐ Type 1 ☐ Type 2 Managed by: ☐ Diet only ☐ Oral meds ☐ Insulin injections ☐ Insulin pump
- ☐ Heart Problems (describe) ____
- ☐ Seizures: Type (describe) ____

There is a condition that may result in an emergency: ☐ yes ☐no (If yes, describe below.)

There is a condition that is being treated with medication: ☐yes ☐no (If yes, describe below.)

There is a condition that may interfere with learning: ☐yes ☐no (If yes, describe below.)

There are physical education restrictions: ☐yes ☐no (If yes, describe below.)

Over

HEALTH EXAMINATION

	Date	Results
Hemoglobin/Hct		
Urinalysis		
Tuberculin (PPD)		mm
Chest x-ray		
Lead		

Height: _______ins.

Weight: ______ lbs.

Blood Pressure ___ / ___

Hearing: ___Normal ___Abnormal

Hearing aid(s): ___yes ___no

Vision: R 20 / __ L 20 / __

Corrected ___Yes ___ No

	Normal	Abnormal
Ears		
Mouth / Dental		
Throat		
Nose		
Lymph Nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Behavior		
Speech		

Describe any abnormal findings / chronic conditions.

Health Concerns	Recommendations for School

Note: A separate medication form is required for all medications and treatment to be administered at school.

Signature and title of health care provider ____________ Print name ____________ Date of physical exam ____________

Clinic name ____________ Phone ____________ FAX ____________

Please return this form to your school nurse.

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision2) 2/27/08