

Last _____ First _____ Middle _____	Birth Date Month/Day/ Year _____	Sex _____	School _____	Grade Level/ ID _____
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES <small>(Food, drug, insect, other)</small>	Yes No	List: _____	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List: _____
Diagnosis of asthma? Child wakes during night coughing?	Yes Yes	No No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes Yes	No No
Birth defects?	Yes	No	Hospitalizations? When? What for?	Yes	No
Developmental delay?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	Serious injury or illness?	Yes	No
Diabetes?	Yes	No	TB skin test positive (past/present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	TB disease (past or present)?	Yes*	No
Seizures? What are they like?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Alcohol/Drug use?	Yes	No
Heart murmur/High blood pressure?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Dizziness or chest pain with exercise?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Information may be shared with appropriate personnel for health and educational purposes.		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Parent/Guardian Signature _____ Date _____		
Ear/Hearing problems?	Yes	No			
Bone/Joint problem/injury/scoliosis?	Yes	No			

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old	HEIGHT	WEIGHT	BMI	BMI PERCENTILE	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) 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 required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes No Blood Test Indicated? Yes No Blood Test Date _____ Result _____

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed Test performed Skin Test: Date Read _____ Result: Positive Negative mm _____
 Blood Test: Date Reported _____ Result: Positive Negative Value _____

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears		Screening Result: _____	Gastrointestinal	
Eyes		Screening Result: _____	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

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: Nurse Teacher Counselor 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 No 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 No Modified **INTERSCHOLASTIC SPORTS** Yes No Modified

Print Name _____ (MD,DO, APN, PA) Signature _____ Date _____
 Address _____ Phone _____