

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

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)				
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. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____				

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

SYSTEM REVIEW	Normal <input type="checkbox"/>	Comments/Follow-up/Needs	Normal <input type="checkbox"/>	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	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 Antagonist) <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** (for one year) Yes No Limited

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

(Complete both sides)