| Student's Name (Last / First / Middle) | Birth Date (Month Day Year) | Sex | School | Grade Level/ ID # |
|---|---|---|---|---|
| | | | | |

**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 | No | Indicate Severity | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Child wakes during the night coughing? | Yes | No | | | | | |
| Birth complications/prematurity? | Yes | No | | Hospitalizations? When? What for? | Yes | No | |
| Developmental delay? | Yes | No | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | | Surgery? (List all.) When? What for? | Yes | No | |
| Diabetes? | Yes | No | | Serious injury or illness? | Yes | No | |
| Head injury/Concussion/Passed out? | Yes | No | | TB skin test positive (past/present)? | Yes* | No | *If yes, refer to local health department. |
| Seizures? What are they like? | Yes | No | | TB disease (past or present)? | Yes* | No | |
| Heart problem/Shortness of breath? | Yes | No | | Tobacco use (type, frequency)? | Yes | No | |
| Heart murmur/High blood pressure? | Yes | No | | Alcohol/Drug use? | Yes | No | |
| Dizziness or chest pain with exercise? | Yes | No | | Family history of sudden death before age 50? (Cause?) | Yes | No | |

Eye/Vision problems? ___ Glasses ☐ Contacts ☐ Last exam by eye doctor ___

Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Dental 9 Braces 9 Bridge 9 Plate Other

Other concerns?

| | | | |
|---|---|---|---|
| Ear/Hearing problems? | Yes | No | |
| Bone/Joint problem/injury/scoliosis? | | | |

Information may be shared with appropriate personnel for health and educational purposes.

**Parent/Guardian Signature** **Date**

## Entire section below to be completed by MD/DO/APN/PA

**PHYSICAL EXAMINATION REQUIREMENTS** **HEAD CIRCUMFERENCE** **HEIGHT** **WEIGHT** **BMI** **B/P**

**DIABETES SCREENING** (Not required for daycare.) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

**LEAD RISK QUESTIONAIRRE** Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. **Questionairre Administered?** Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Blood Test Result**

(If child resides in Chicago, blood test is required.)

**TB SKIN TEST** Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. ☐ No Test Needed ☐ Test performed **Date Read** / / **Result** **mm**

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

| SYSTEM REVIEW | Normal | Comments/Follow-up/Needs | | Normal | Comments/Follow-up/Needs |
|---|---|---|---|---|---|
| Skin | | | Endocrine | | |
| Ears | | | Gastrointestinal | | |
| Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result ___ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐ | | | Genito-Urinary | | LMP |
| | | | Neurological | | |
| Nose | | | Musculoskeletal | | |
| Throat | | | Spinal examination | | |
| Mouth/Dental | | | Nutritional status | | |
| Cardiovascular/HTN | | | Mental Health | | |
| Respiratory | | | | | |

**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 ☐**

Physician/Advanced Practice Nurse/Physician Assistant performing examination

**Print Name** **Signature** **Date**

**Address** **Phone**

**(Complete both sides)**