HEALTH SERVICES DEPARTMENT

School Entry Physical Examination

TO BE COMPLETED BY PARENT ______

Student's name (*last, first*) ______ Birth date ___/___/___

SEX: [ ] M [ ] F Street address ______ School ______ Grade____

Parent/Guardian name ______ Home phone ______

Check health conditions below that affect your child.

[ ] ADD/ADHD
[ ] allergies
[ ] asthma
[ ] bee sting allergy
[ ] chickenpox (date ______)
[ ] cystic fibrosis
[ ] diabetes
[ ] food allergy
[ ] G.I. disorder
[ ] hearing loss
[ ] heart condition
[ ] kidney disorder
[ ] malignancy
[ ] neurological disorder
[ ] seizures
[ ] sickle cell anemia
[ ] visual impairment
[ ] other ______

Give a brief history of serious accidents, surgeries and/or health conditions of your child. ______

List medication your child is taking regularly. ______

Parent/Guardian signature ______ Date ______

TO BE COMPLETED BY PHYSICIAN ______

HT ______ WT ______ Bp ______ LEAD TEST: Date___/___/___ [ ] capillary or [ ] venous Result ______

**Lead testing only iff physician deems applicable*

	NORM.	*ABNORM.*	*REMARKS*
Eyes			Vision: RT LT
ENT			
Lungs			
Heart			
Abdomen			
Hernia			
Extremities			
Neuro			
Skin			

Other conditions/disabilities: ______

Urine *(if applicable)*: Alb ____ Sugar ____ Should child be restricted from any activities? [ ] yes [ ] no If yes, explain. ______

Physician's signature ______ Date ______