<u>Medical History</u>: **(To be completed by parent)**

<u>Eyes</u>: Glasses____ (reading____ distance____) Contacts ____
Other____
<u>Ears</u>: frequent infections ___________________ tubes ______
Hearing difficulty (explain) ____________________________
Hearing aid – right ____ left ____ wear at school ____

<u>Allergies</u>: (drugs, food, insects, pollens)
Please list: ____
Has the allergy ever required emergency action? (explain)

<u>Asthma</u>: Yes ____ No ____ Triggered by: ________________
Treatments/Medications: ______________________________
Diagnosed by physician (date): _________________________

<u>Seizures</u>: Yes ____ No ____ Date of last seizure: ____
Describe seizure: _____________________________________
Medication: ____

<u>Other Medications/Inhaler</u>: ____________________________
____
Reasons for taking: ___________________________________

<u>Other Health Concerns</u>: diabetes ___ heart problem ___
bleeding ___ eating ___ sleeping ___ bowel ___ bladder ___
bed wetting ___ dental ___ skin ___ menstrual history ___
phobias (fears) ___ blood pressure ___ orthopedic ___
neurologic ___ headaches ___ blood disorder ___ lungs ___
sickle cell anemia ___ TB exposure ___
EXPLAIN: ____
____

<u>Other illness, injury, or health problems that might affect performance at school</u>: ____________________________________
____

<u>Physical Examination</u>: (To be completed by physician)

Growth Measurements:
Height: ____________________ Weight: ___________________
Dietary restrictions: ____

Physiologic Measurements:
Temp: _________ Pulse: _________ Respiration: _________
Blood Pressure: ____________ Urinalysis: _______________

Physical Exam:
General Appearance: ____
Skin: ____
Head: ____
Neck: ____
Eyes: ____
Vision Test: Both _____ Right: _____ Left: _____
Ears: ____
Hearing Test: pass fail
Nose/Mouth/Throat: ____
Chest: ____
Abdomen: ____
Genitalia: ____
Back and Extremities: ______________________________________
Neurologic Exam: ____

Chronic conditions and treatment: ______________________________
____
____
Should physical activity be restricted? Yes _____ No _____
If yes, specify degree ____
Other restrictions ____
Preferential Seating ____

Signature: ____
Date: __________ Date of Examination: ______________________