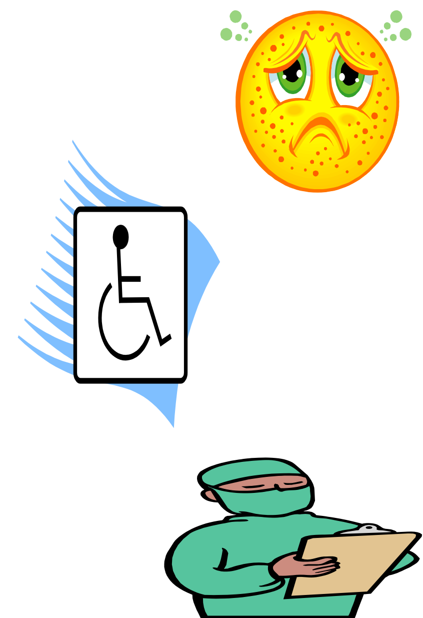
History and Physical Examination Form
2014 – 2015

Child's Full Name: ____
Child's Date of Birth: ____________________________________

Parent/Guardian: Please complete this section:

Child's past history - please check and give date(s) if your child has had:



Allergies (specify) ________________________________
Visual Difficulty ________________________________
Asthma ____
Chicken Pox ____________________________________
Diabetes ______________________________________
Mumps ____
Physical Handicap (specify) __________________________
Seizures ______________________________________
Serious injury (specify) ____________________________
Surgery (specify) _________________________________
Measles _______________________________________
Other ____

Did you child complete preschool screening in District 885? yes ___ no ____
If you selected NO, please tell us what district your child was screened in_______________
****If your child has not been screened, please contact Heather Knudson to schedule a screening appointment. (763) 497-2688 Extension 92006****

Please use this space to elaborate on any concerns or special needs you feel your child may encounter at school

Would you like to schedule an appointment with the school nurse? _______________
Parent/Guardian Signature: ______________________Date: __________________

*****Please have your physician complete the OTHER side of this form*****

PHYSICIAN: Please complete the section below:

Physical Examination:

Skin/Lymph_____________ Mouth________________ Lungs______________
Neurological_____________ Eyes_________________ Throat_____________
Abdomen_______________ Speech_______________ Ears_______________
Neck__________________ Nose_________________ Genito-urinary_______
Nutrition_______________ Heart________________ Orthopedic_________
Emotional________________

Further explanation necessary for any of the above:

____

____

Treatment plan/followup: ____

Ongoing therapies & medications (specify type & dose):____

____

Height:_______________ Percentile:________________

Weight:_______________ Percentile:________________

Blood Pressure:______________ Hemoglobin:__________ Urine:_____________

Vision: R20/ L20/ with glasses? ______

Hearing: R ______ L ______

Immunizations given at this exam:

____

Medications &/or treatments to be administered at school:

____

Is a modified diet necessary?: __________ If yes, please specify_________________

____

Is there is a condition that may result in an emergency situation?: yes ____ no ____

If yes, specify:

____

Health Classification for School Program:

_________Is in good health and able to participate in the entire school program.

_________There is a condition which may limit participation.

(Circle those that apply and explain)

Classroom Activities **Physical Education** **Competitive Sports**

Is this limitation temporary or permanent? (Circle one)

If temporary, state time frame: ______________________________

Physician's Signature _________________________

Date of Exam ____________ **Phone:** _______________ **Clinic Name:**_________________

Physician Name (print or type): ____