

HISTORY AND PHYSICAL EXAMINATION FORM

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 _____

Hospital preference _____

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 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 _____

Best phone number to reach you at during the school day _____



*****Please have your Physician complete the OTHER side of this form.

PHYSICIAN: Please complete the section below:

Child's Name _____

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 _____

Physician's Signature _____

Date of Exam _____ Telephone _____ Clinic name _____

Physician Name (print or type) _____