HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

PARENTS: In order for your child to attend school, this form must be completed, signed, and returned to school.

Please complete this form before taking your child to the doctor.

Child's name _____ Birthdate _____ M __ F __

Address _____ Home phone _____

Father's name _____ Mother's maiden name _____

PLEASE ANSWER "YES" OR "NO" AFTER EACH ITEM.

Family History of:

Tuberculosis _____ Cancer _____ Heart Disease _____
Diabetes _____ Asthma _____ Rhuematic fever _____ Congenital heart disease _____ Ear infections _____ Rubeola (hard measles) _____ Mumps _____ Rubella (German measles or 3-day measles) _____ Chicken pox _____ Whooping cough _____ Scarlet fever _____ Strep throat _____ Infectious hepatitis (infectious jaundice) _____ Other _____

Does your child have problems with any of the following?

Skin _____ Eating _____ Bowels _____ Urination _____
Sleeping _____ Muscles or bones _____ Heart or lungs _____
If yes, please describe:

_____

_____

Has your child had any serious injuries? _____ If yes, please describe:

_____

_____

Has your child ever been hospitalized? _____ Reason:

_____

_____

Does your child take any medication regularly? _____

Medication _____ Frequency _____ Reason _____

Does you child wear glasses? _____ Color blind? _____

Does your child have a hearing problem? _____

Has your child ever had a TB skin test? _____ If so, when? _____
Results: _____

Was your pregnancy with this child: 9 months? _____ longer? _____
shorter? _____

Any illness during pregnancy? _____

Any complications at delivery (mother or baby)? _____

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FOR THE PHYSICIAN

This should be a complete physical examination with evaluation of the following:

eyes, ears, nose, mouth, throat, heart, lungs, nutritional status, laboratory work as indicated, any needed immunization.

FINDINGS:

Medications: _____

_____

Vision:
Right: 20/_____ Left: 20/_____

Other: _____

Recommendations:

_____ recheck child

_____ further immunization needed

_____ refer to specialist

_____ special conference with school personnel

Date: _____ _____
Signature of examining physician

NOTE: PARENTS ARE TO RETURN THIS COMPLETED FORM TO ST. JOHN'S LUTHERAN SCHOOL