

Last			First			Middle			Birth Date Month/Day/Year			Sex		School		Grade Level/ID	
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER																	
ALLERGIES (Food, drug, insect, other)		Yes No		List:				MEDICATION (Prescribed or taken on a regular basis)		Yes No		List:					
Diagnosis of asthma?				Yes No		Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)				Yes No					
Child wakes during night coughing?				Yes No		Yes No		Hospitalizations? When? What for?				Yes No					
Birth defects?				Yes No		Yes No		Surgery? (List all.) When? What for?				Yes No					
Developmental delay?				Yes No		Yes No		Serious injury or illness?				Yes No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain				Yes No		Yes No		TB skin test positive (past/present)?				Yes* No		*If yes, refer to local health department.			
Diabetes?				Yes No		Yes No		TB disease (past or present)?				Yes* No					
Head injury/Concussion/Passed out?				Yes No		Yes No		Tobacco use (type, frequency)?				Yes No					
Seizures? What are they like?				Yes No		Yes No		Alcohol/Drug use?				Yes No					
Heart problem/Shortness of breath?				Yes No		Yes No		Family history of sudden death before age 50? (Cause?)				Yes No					
Heart murmur/High blood pressure?				Yes No		Yes No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other									
Dizziness or chest pain with exercise?				Yes No		Yes No		Information may be shared with appropriate personnel for health and educational purposes									
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Yes No		Yes No		Parent/Guardian Signature				Date					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Yes No		Yes No											
Ear/Hearing problems?				Yes No		Yes No											
Bone/Joint problem/injury/scoliosis?				Yes No		Yes No											
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA																	
HEAD CIRCUMFERENCE if <2-3 years old			HEIGHT			WEIGHT			BMI			B/P					
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>																	
LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)																	
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Result _____																	
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm																	
No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____																	
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____																	
LAB TESTS (Recommended)		Date		Results				Date		Results							
Hemoglobin or Hematocrit				Sickle Cell (when indicated)													
Urinalysis				Developmental Screening Tool													
SYSTEM REVIEW		Normal		Comments/Follow-up/Needs				Normal		Comments/Follow-up/Needs							
Skin				Endocrine													
Ears				Screening Result:				Gastrointestinal									
Eyes				Screening Result:				Genito-Urinary				LMP					
Nose				Neurological													
Throat				Musculoskeletal													
Mouth/Dental				Spinal Exam													
Cardiovascular/HTN				Nutritional status													
Respiratory				<input type="checkbox"/> Diagnosis of Asthma				Mental Health									
Currently Prescribed Asthma Medication:				Other													
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																	
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																	
NEEDS/MODIFICATIONS required in the school setting								DIETARY Needs/Restrictions									
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																	
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal																	
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem) ³ Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.																	
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)																	
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																	
Print Name				(MD, DO, APN, PA) Signature				Date									
Address						Phone											