HEALTH HISTORY & PHYSICAL AND IMMUNIZATION FORM

Independent School District # 709
School Health Services

STUDENT INFORMATION - To be completed by parent

Name______________________________ π Male π Female Birth Date____/____/____

Address______________________________ Phone # ____________________

Father or Guardian____________________ Place of Work____________________ Phone # ____________________

Mother or Guardian____________________ Place of Work____________________ Phone # ____________________

In Emergency, Notify______________________________ Phone # ____________________

Physician______________________________ Dentist ______________________________

School______________________________ Grade __________ Home Room ____________________

Last School Attended ______________________________ City ______________________________

PLEASE CHECK (4) THE HEALTH CONCERNS YOUR CHILD HAS HAD:

Allergy (Specify__________________)	Epilepsy	Red Measles (Rubeola)	Scarlet Fever
Asthma	Eye Trouble	German Measles (Rubella)	Strep Throat
Eczema	Frequent Headaches	Mumps	Stomach Trouble
Hayfever	Hearing Trouble	Nervousness	Tonsilitis
Chicken Pox	Ear Aches	Bone or Muscle Trouble	Tuberculosis
Frequent Colds	Draining Ear	Pneumonia	Whooping Cough
Diabetes	Heart Trouble	Rheumatic Fever	

Comment on major illness, operations, injuries or other health problems______________________________

____

Is your child on any medication on a regular or long-term basis? π Yes π No

If YES, please pedify____

Has your child ever been hospitalized? π Yes π No If YES, for what and at what age? ______________________________

____

DENTAL EXAMINATION – To be completed by dentist

Dental Examination:

1. Normal dentition present.......................... Yes No
2. Normal occlusion.................................... Yes No
3. Soft tissues normal................................. Yes No
4. Abscesses or infection present................ Yes No
5. Dental Caries...... Rampant Moderate None
6. Dental Care......... Routine treatment required
   Urgent treatment required
   Topical fluoride applied
   No further treatment needed at this time

Comments or recommendations to school nurse: ____________________

____

____

This is to verify that:

____
Name of Student

Has had all dental treatment that is necessary at this time.

________________ ______________________________DDS
Date Signiture of Dentist

HEALTH EXAMINATION – To be completed by physician

Name ____

Height_________________ Weight_________________

Hgb. Or Hct. ____

Urine____

Eyes: Vision ……………….….R 20 / _______ L 20 / ______

Glasses Worn…………………… π Yes π No

Contacts …………………….…. π Yes π No

Hearing……………………….….. R _______ L _______

Blood Pressure ____

List Positive Findings of Complete Medical Examination:

____

____

____

____

____

Scoliosis……………….………._______Neg. _______ Pos.

Developmental:		***Normal***	***Abnormal***
Gross Motor ……………………..….		_______	_______
Fine Motor……………………..……….		_______	_______
Screening tool used:____________________			

	Normal	***Abnormal***
Concepts ……………….…...….	_______	_______
Speech………………………… .	_______	_______
Screening tool used________________________		

Recommendations regarding treatment and correction: ____

Any condition which may result in an emergency? π Yes π No If YES, please specify__________________________

____

List other health concerns that could interfere with learning: ____

____

What emotional problems, if any, should be watched for? ____

____

List medications the child is on: ____

____

Has this child had chicken pox disease? π Yes π No Year of disease? ___________________________________

IIs there a condition which may limit participation in:

A. Classroom activity? π Yes π No
B. Physical Education? π Yes π No
C. Competitive sports? π Yes π No

I If YES, please specify ____

Comments and recommendations: ____

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____

____

Date ______________________________ Signature____M.D.

Also, complete documentation of immunization on next page, or

Attach copy of clinic immunization record.