

PRIVATE PHYSICIAN'S EXAMINATION REPORT

Student's Name _____ DOB _____

Examining Physician _____
(Print)

Date of Exam _____ Physician's Phone Number _____

Height _____ Weight _____ Blood Pressure _____

Scalp, Head, Neck _____

Eyes _____ Last Eye Exam _____

Ears _____ Last Hearing Exam _____

Nose _____

Mouth and Throat _____

Chest and Lungs _____

Heart _____

Abdomen, Hernia _____

Genitals _____

Extremities _____

Skin _____

Posture, Gait, Spine _____

Coordination _____

Blood Pressure _____

Restrictions _____

Referral Needed YES _____ NO _____

Immunizations _____ **Please attach shot record*

**6th grade students: Meningococcal vaccine Date _____

Tdap Date _____

Physician's Signature _____

Student Health Inventory

Teacher _____ Grade _____ School _____

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the School Nurse.

Name _____ Birthdate _____ Boy Girl
Last First Middle

Parent/Guardian _____ Phone # _____

Parent's employment _____
Father Phone Mother Phone

Emergency Contacts _____
 (Other than parent) Name Phone Name Phone

Last School attended _____
Name City State

Doctor's name _____ Date of last physical _____

Dentist's name _____ Date of last exam _____

Is student under an orthodontist's care? Yes No Doctor's name _____

Does student have:
 Allergies? Yes No To drugs, food, insects, pollen? Please list _____
 Has the allergy required emergency action in the past? Yes No
 Comments _____

Bee sting allergy? Yes No Describe reaction _____
 Difficult breathing? Yes No Need emergency medication? Yes No

Asthma? Yes No Triggered by _____ Treatment _____
 Diagnosed by doctor _____ Date _____

Diabetes? Yes No Takes insulin? Yes No Date Diagnosed _____
 Epilepsy/Seizures Yes No Describe seizure _____

Heart condition? Yes No Date of last seizure _____ Medication _____
 Is student currently under a doctor's care for seizures? Yes No

Bone or joint problems? Yes No Describe _____
 Any physical restrictions? _____ Medication? Yes No

Describe _____
 Any physical restrictions? _____

Check off the following regarding health concerns that pertain to student:

- | | |
|--|--|
| Eyes: Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Difficulty seeing <input type="checkbox"/>
<input type="checkbox"/> Reading <input type="checkbox"/> Crossed <input type="checkbox"/> Lazy Eye <input type="checkbox"/>
<input type="checkbox"/> Distance <input type="checkbox"/> | Ears: <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Hearing Aid <input type="checkbox"/>
<input type="checkbox"/> Tubes <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/>
<input type="checkbox"/> Hearing difficulty, explain <input type="checkbox"/> Wear at School <input type="checkbox"/>
<input type="checkbox"/> Other <input type="checkbox"/> |
| Other: <input type="checkbox"/> nosebleeds <input type="checkbox"/> eating <input type="checkbox"/> sleeping <input type="checkbox"/> bladder <input type="checkbox"/> skin <input type="checkbox"/> phobias <input type="checkbox"/> bedwetting
<input type="checkbox"/> lungs <input type="checkbox"/> neurologic <input type="checkbox"/> headaches <input type="checkbox"/> bowel <input type="checkbox"/> dental <input type="checkbox"/> ADD/ADHD | |

Daily medication at home? Yes No At school? Yes No Emergency only? Yes No
 Name of medication and reason for taking _____
 List serious illness or injuries _____
 Surgeries (operations) _____ Condition that prevents PE participation _____
 Other health information or concerns _____

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office.

**MEDICAL PERMISSION
for
SCHOOL HEALTH SERVICES**

Child's Name _____ Grade _____

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. Height and weight
2. Vision screening
3. Hearing screening
4. Scoliosis screening in 5th and 7th grades
5. Blood Pressure Screening

I also give permission for my child's medical information to be shared with the appropriate teachers if necessary for his/her safety and well being.

Parent's Signature _____

Date _____

This Medical Permission Form allows your child to participate in the School Health Program. It will cover your child through the 8th grade. It will be incorporated into your child's health records.

You will still be notified before the scoliosis screening and may withdraw permission for any procedure, at any time.