Confidential Student Health History/Examination Form

(**Section A-E** completed by parent/guardian / **Section F** completed by practitioner)

Student Name: _____ Birth Date: ___/____/_____

Grade: _____ School Attending: _____ Language spoken at home: _____

Height: _____ Weight: _____

A. Health Information:

YES	NO		
		Were there any complications during birth?	If yes, specify:
		Did your child meet all typical milestones?	If no, specify:
		Has your child ever been hospitalized?	If yes, specify:
		Has your child had a dental exam in the last 12 months?	Date of Exam:
		Has your child had a well-check exam in the last 12 months?	Date of Exam:
		Has your child had a vision exam in the last 12 month? Does your child wear corrective lenses? ☐ Yes ☐ No	Date of Exam: Results:
		Has your child had a hearing exam in the last 12 month? Does your child wear hearing aids? ☐ Yes ☐ No Frequent ear infections? ☐ Yes ☐ No	Date of Hearing Exam: Results:
		Does your child have and restrictions placed on their physical activity? Ability to use arms for lifting/reaching/pulling? ☐ Yes ☐ No Ability to use legs for walking/running/climbing? ☐ Yes ☐ No	If yes, specify:
		Does your child have any gastrointestinal issues (Examples: constipation, frequent stomach aches)?	If yes, specify:
		Does your child have any special dietary needs?	If yes, specify:
		Does your child have any cardiac concerns?	If yes, specify:
		Does your child have any cognitive concerns?	If yes, specify:
		Does your child have any mental health concerns?	If yes, specify:
		Does your child have any skin concerns?	If yes, specify:

B. Chronic Illness Information:

YES	NO		
		Does your child have asthma? ☐ Intermittent ☐ Persistent ☐ Exercise Induced Rescue Inhaler required during school? ☐ Yes ☐ No	If yes, please complete an *Asthma Action Plan Form* with your practitioner.
		Does your child have life threatening allergies? List allergen: _____ Will emergency medication be required at school (examples: EpiPen, anti-histamine)? ☐ Yes ☐ No	If yes, please complete an *Anaphylaxis Emergency Action Plan Form* with your practitioner.
		Does your child have diabetes? ☐ Type 1 ☐ Type 2	If yes, please complete a *Health Care Plan for Diabetes Management Form* with your practitioner.
		Does your child have seizures? Type: _____	If yes, please complete at *Seizure Action Plan* with your practitioner.
		Does your child have other chronic illnesses?	Please specify:

C. Developmental Concerns: (Only to be completed for students entering Pre-Kindergarten or Kindergarten)

YES	NO		
		Does your child have any toileting concerns	If yes, specify:
		Does your child have any sleeping problems?	If yes, specify:
		Does your child have any speech issues:	If yes, specify:
		Has your child received any Birth to 3 Services?	If yes, specify:
		Does your child have any fears that may impact daily routine?	If yes, specify:

D. Medication Information:

YES	NO		
		Does your child take any scheduled medications daily at home?	If Yes, list medication and reason Medication: Reason:
		Will your child be requiring over-the counter medications at school?	If yes, please complete a *Medication Authorization Form*.
		Will your child be requiring prescription medication at school?	If you, please complete a *Prescription Medication Authorization Form* with your practitioner. (Asthma, Anaphylaxis, Diabetes and Seizure have separate authorization forms)

E. Education Plan:

YES	NO	
		Does your child have an Individual Education Plan (IEP) or a Section 504 Plan?

Primary Care Practitioner's Name: _____ Number: _____

Dentist Name: _____ Number: _____

Please submit immunization dates on the *Wisconsin Immunization* Form included in your packet.

Parent consent to allow my child's healthcare provider(s) (listed above) and school personnel to discuss health related concerns in case of emergency and parents are not able to be reached.

Parent/Guardian Signature:

_____Date:_____

F. Health Examination (Section to be completed by medical practitioner)

Student Health Examination Form

Student Name: _____ Birth Date: _____

Date of Physical Exam: _____ Height: _____ Weight: _____ BP: _____ Pulse: _____

Visual Acuity R: _____ L: _____ Hearing: R: _____ L: _____

General Exam - Results: Within Normal Limits (WNL) or Specify anomalies with restrictions

	Results		Results
Eyes		Neurological	
Ears		Skin	
Nose		Ortho / Joint	
Respiratory		Immune System	
Cardiac		Mental Health	
Abdominal / GI		Other:	

Ongoing Chronic conditions that you or another health care provider is following this student for:

_____

_____

Immunizations:

☐ All up to date ☐ Given today (List vaccine/s):_____

Practitioner Name (Print & Sign):	Practitioner Address:	Practitioner Phone:

All students prior to enrollment in the district are strongly encouraged to have a medical exam performed by a licensed practitioner. Students entering kindergarten shall be requested to provide evidence of an eye examination by an optometrist or physician as provided in Wis. Stats. 118.135(1).