

Parent or Guardian: Please complete this section prior to seeing physician.

Last name _____ First name _____ Gender: M F Date of birth _____

Parent/Guardian _____ Address _____ City/State/ZIP _____

Parent/Guardian home phone _____ Mobile phone _____ Email address _____

Grade _____ Age _____ Emergency contact (name and phone) _____

Past History — Indicate if your child has ever had:

- Asthma
 - Chickenpox
 - Convulsions
 - Diabetes
 - Epilepsy
 - German measles
 - Heart disease
 - High temperature
 - Mumps
 - Red measles
 - Rheumatic fever
 - Scarlet fever
- Other (specify): _____
- Serious accident (specify): _____
- Surgery (specify): _____
- Allergies (specify): _____

Current History — Indicate if your child has recently had problems with:

- Abdominal pain
- Allergies
- Asthma
- Bladder problems
- Bleeds easily
- Bowel problems
- Clumsiness
- Dizziness
- Ear trouble (3 or more/year)
- Fainting spells
- Frequent sore throat
- Hard of hearing
- Joint pains
- Persistent cough
- Physical handicap
- Poor vision
- Shortness of breath
- Speech difficulty
- Strep throat (3 or more/year)
- Thumb sucking
- Tires easily
- Trouble sleeping
- Other (specify): _____

Parent/Guardian signature _____ Date _____

Physician: Please complete this section.

Immunizations — Type of Vaccine	Dose 1 Month/Day/Year	Dose 2 Month/Day/Year	Dose 3 Month/Day/Year	Dose 4 Month/Day/Year	Dose 5 Month/Day/Year
Diphtheria, Tetanus and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) (formulation for less than 7 years old)					
Tetanus and Diphtheria (Td, Tdap) (formulation for 7 years old and older)					
Polio (IPV, OPV)					
Measles, Mumps and Rubella (MMR)					
Hepatitis B (hep B)					
Varicella (chickenpox)					
Pneumococcal Conjugate (PCV)					
Haemophilus influenzae type B (Hib)					
Meningococcal (MPSV4, MCV4)					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Rotavirus					
Other (specify)					

Examination — indicate Normal (N) or Abnormal (AB). If Abnormal, comment below.

	N/AB
Skin/Lymph	
Eyes	
Ears	
Nose	
Mouth	
Throat	
Neck	
Heart	
Lungs	
Abdomen	
Genito - Urinary	
Orthopedic - Feet	
Orthopedic - Spine	
Neurological	
Speech	
Other (specify)	

Tests — indicate Normal (N) or Abnormal (AB). If Abnormal, please comment below.

Test	N/AB	Test	N/AB
Tuberculin		Urine	
Hemoglobin/Hematocrit		Scoliosis	

Measurements — Give exact value.

Blood pressure	
Height	
Weight	
BMI	

Vision: R 20/____ L 20/____
With glasses? Yes No

Hearing: R _____ L _____
With hearing aid? Yes No

Health Classification for School Programs

- Is in excellent health and able to participate in all school programs.
- There is a condition that may limit participation in (circle as many as apply):
Classroom activities Physical Education Competitive sports
Reason(s) and recommendation(s): _____
Is the above classification temporary? Yes No For how long? _____

Is there a condition that may result in an emergency situation? Yes No
If yes, specify: _____
Ongoing therapies and medications — specify type and dose: _____

Problems/Comments (as indicated above)	Recommendations or plans