ALAMEDA UNIFIED SCHOOL DISTRICT
HEALTH HISTORY AND PHYSICAL EXAMINATION

The school district will keep and maintain this as confidential information.

Name _____ **Birthdate** _____ **Male Female School**_____

REASON FOR REFERRAL: PRESCHOOL CHDP KINDERGARTEN/FIRST GRADE HIGH SCHOOL SPECIAL PLACEMENT ATHLETICS

FOR THE FOLLOWING CONCERNS:_____

PARENT/GUARDIAN AUTHORIZATION: For release of health information, I hereby give my consent to the school named above to receive from, or send to the following health care professional, Dr._____**, any health information concerning my child.**

Parent/Guardian Signature_____ **Date** _____

STUDENT HEALTH HISTORY - To be completed by parent or guardian

Currently under the care of_____ **For what condition?**_____
Doctor's Name

Currently under the care of_____ **Medication: Please indicate the name and dosage of any medication that your child**
Dentist's Name **is taking.** _____

CHECK ANY CONDITIONS THAT APPLY

___Allergies, Asthma, Hay Fever	___Dental Problem	___Kidney Problem	___Surgery(kind/date)
___Anemia,Blood disorder	___Diabetes	___Orthopedic Problem	___Tuberculosis (Tb)
___Cancer	___Ear,Hearing Problem	___Speech	___Vision, Eye Problem
___Colon Problem	___Heart Defect	___Stomach Problem	___ Other

Further explanation of above:_____

MEDICAL EXAMINATION – To be completed by physician

IMMUNIZATION RECORD: Insert month, day, and year each dose was given

VACCINE	1ST	2ND	3RD	4TH	5TH	6TH
Polio	/ /	/ /	/ /	/ /	/ /	/ /
DPT/DTaP/Td	/ /	/ /	/ /	/ /	/ /	/ /
MMR (Measles, Mumps,Rubella	/ /	/ /	2 doses required for kindergarten and grade 7			
Hepatitis B	/ /	/ /	/ /	3 doses required for kindergarten and grade 7		
H1B Meningitis	/ /	/ /	/ /	/ /	Required for child care	
Varicella (Chickenpox)	/ /	/ /	1 dose required for kindergarten; 2 doses required over the age of 13, out of state, or out of the U.S.			

REQUIRED TEST RESULTS

Health and Development History_____ **Nutritional Assessment**_____ **Height** _____ **Weight** _____

Hearing Test _____ **Vision Test** _____ **Hematocrit/Hemoglobin** _____ **Urinalysis** _____ **Blood Pressure** _____

Tb SKIN TEST (If required for school entry, must be Mantoux unless exception granted by the local health officer*)

TYPE **Date Given** **Date Read** **mm induration** **Impression**
PPD/Mantoux / _____ _____ _____ **Positive Negative**
Other

CHEST X-RAY (required if skin test is positive)
Film Date:_____
Impression: Normal Abnormal (Circle One)
Student is free of Communicable disease: YES NO

FOR THIS PHYSICAL EXAM TO QUALIFY AS MEETING THE CHDP KDG/1ST GRADE REQUIREMENT ALL TESTS AND EVALUATIONS MUST BE DONE WITHIN 6 MONTHS PRIOR TO THE START OF KDG.

SIGNIFICANT FINDINGS: (Optional. Fill out if release is signed by parent or guardian and an interpretation of medical findings is needed)
_____
_____
RECOMMENDATIONS:_____
_____
FURTHER EVALUATION IS NEEDED FOR:_____
RECOMMENDATION FOR PHYSICAL ACTIVITY: Unrestricted Restricted Cleared for Athletic Participation and/or Competitive Sports
MEDICATION: Name and Dosage_____
MEDICAL CARE: Is this child currently under your care:_____ **How long?**_____ **Other Specialists Involved?**_____

IN MY OPINION, IT WOULD BE BENEFICIAL TO DISCUSS THIS FURTHER, AND REQUEST THAT THE HEALTH OFFICE ASST. CONTACT ME. YES/NO
Stamped or printed name and address of physician below.

_____ _____
Physician's Signature (Required) **Date**

**** If your family does not have health insurance and you would like information regarding the MediCal/Healthy Families program, call toll free, 1-888-747-1222**