

Physical Exam Form

Required for students 8 years old and younger new to Kansas Schools

Name: _____

Birthdate: _____

Family Health History:

Response Codes: M = Maternal P = Paternal S = Sibling NA = Not applicable

	Code	Comment
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions, mental illness, substance abuse, or others? Comment?		
2. Does any family member have a vision defect, hearing loss, or spinal deformity? Comment?		

Child/Adolescent History:

Response Codes: Y = Yes N = No NA = Not applicable

1. Birthweight _____ Were there any pre-natal or delivery problems with the child?		
2. Did this child walk, talk, and develop at the usual time?		
3. Does this child/adolescent:		
a. See a health care provider regularly?		
b. Use any medication, drugs, or alcohol?		
c. Have a history of any hospitalizations, surgeries, or emergency room visits?		
d. Have a history of any childhood diseases/illnesses?		
e. Have a history of other communicable diseases?		
f. Age menarche _____ Have a history of menstrual problems?		
g. Have a history of vision, speech, hearing, or communication problems?		
h. Have a problem with being tired or overactive?		
i. Have any emotional or behavioral problems?		
j. Need any special help in school or day care?		
k. Have sexuality concerns?		
l. Have any chronic illness or disabling problems with:		

Headache _____ Convulsions _____ Diabetes _____ Earaches _____ Back/spine/

Cold/sore throat _____ Rheumatic fever _____ Genitalia _____ Oral/dental _____ extremity problem _____

Heart/lung disease _____ Allergies/asthma _____ Digestive _____ Urinary/bowel _____ Other _____

List present concerns of child/parent/guardian:

A copy of the student's shot record is required at enrollment.

BRING THIS COMPLETED PAGE 1 WITH YOU TO THE PHYSICAL EXAM

Name: _____

Physical Examination: To be completed by health care provider approved to perform health assessments.

Height _____ Weight _____ Hgb or Hct _____
Pulse _____ Blood Pressure _____ Lead _____
Urinalysis _____ Sickle Cell _____ Other _____
Tuberculosis _____ Head Circumference _____ BMI% _____

Code Each Item as Follows:

0 = No significant findings
1 = Significant findings

Code

Description of Findings

General Appearance
Integument
Head – Neck
EENT
Oral – Dental
Thorax
Breasts
Cardiovascular
Abdomen
Musculoskeletal
Genitourinary
Neurological

Screening:

1. Nutritional Evaluation (all ages – each screen) (✓ if applicable) Nutrition/WIC Questionnaires available from (913) 296-0092.
 Enroll in WIC Receiving Vitamin Supplement with iron Without iron Fluoride Supplement

Food intake review. Results:

milk/milk products (breastfed/type of formula) _____
fruit/vegetables _____
meats, beans, eggs _____
breads, cereals _____

2. Development: Type of screen _____ Results _____
3. Speech: Type of screen _____ Results _____
4. Hearing: Type of screen _____ Results _____ Date of last screen _____
5. Vision: Type of screen _____ Results _____ Date of last screen _____

Significant Assessment Findings:

Anticipatory Guidance: (circle those discussed)

- 1. Safety/poisons
- 2. Nutrition
- 3. Parenting
- 4. Family Planning
- 5. Discipline
- 6. Immunization
- 7. Hygiene
- 8. Lifestyle
- 9. Development
- 10. Behavior
- 11. Sexuality
- 12. Dental
- 13. Other

Recommendations: (include referrals)

Comments:

This student is cleared for participation in all organized youth sport/activities Yes _____ No _____

Additional information may be attached

Signature of Licensed Physician/Nurse approved to perform health assessments

Date

