MILLVILLE AREA SCHOOL DISTRICT

MILLVILLE, PENNSYLVANIA

. Permission to see the School Physician

Student's Name_____ Date of Birth_____ Grade_____ Date_____

I give my child permission to be seen by the school physician to fulfill the requirement of a physical during the school year.

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian Signature Date .

I will be present for the exam ( ) YES ( ) NO

Student Health History

Allergies ( ) YES ( ) NO

If yes, please list allergies: _____

Asthma/Lung Disorders ( ) YES ( ) NO

Bleeding Disorders ( ) YES ( ) NO

Born without or missing any organ ( ) YES ( ) NO

Concussion ( ) YES ( ) NO

Daily Medications or Supplements ( ) YES ( ) NO

Dental Problems ( ) YES ( ) NO

Diabetes ( ) YES ( ) NO

Frequent headaches or migraines ( ) YES ( ) NO

Glasses/Contacts/Hearing Aids ( ) YES ( ) NO

Heart or Blood Pressure Problems ( ) YES ( ) NO

History of urinary tract infections or bedwetting ( ) YES ( ) NO

Kidney Problems ( ) YES ( ) NO

Neurological Problems/Convulsions ( ) YES ( ) NO

Ever had a seizure? ( ) YES ( ) NO

Orthopedic Conditions/Scoliosis ( ) YES ( ) NO

Stomach Problems ( ) YES ( ) NO

Other ( ) YES ( ) NO

Ever had surgery? ( ) YES ( ) NO

If you have answered yes to any of the above questions, please elaborate: