FWCS
We Are Your Schools

HEALTH and WELLNESS SERVICES

School Entry Physical Examination

TO BE COMPLETED BY PARENT

Student's name (*last, first*) _____ Birth Date ____/____/____

SEX [ ] M [ ] F Street address _____ School _____ Grade _____

Parent/Guardian name _____ Phone _____

Check health conditions below that affect your child.

[ ] ADD/ADHD	[ ] cystic fibrosis	[ ] heart condition	[ ] sickle cell anemia
[ ] allergies	[ ] diabetes	[ ] kidney disorder	[ ] visual impairment
[ ] asthma	[ ] food allergy	[ ] malignancy	[ ] other _____
[ ] bee sting	[ ] G.I. disorder	[ ] neurological disorder	_____
[ ] hearing loss	[ ] seizures	[ ] chickenpox (date _____)	_____

Give a brief history of serious accidents, surgeries and/or health conditions of your child. _____

_____

_____

List medication your child is taking regularly _____

Parent/Guardian _____ Date _____

TO BE COMPLETED BY PHYSICIAN

HT _____ WT _____ BP _____ LEAD TEST: Date ____/____/____ [ ] capillary or [ ] venous Result

* *Lead testing only if physician deems applicable*

	NORM.	ABNORM.	REMARKS
EYES			Vision: RT LT
ENT			
LUNGS			
HEART			
ABDOMEN			
HERNIA			
EXTREMITIES			
NEURO			
SKIN			

Other conditions/disabilities _____

Urine (*if applicable*): Alb _____ Sugar _____ Should child be restricted from any activities? [ ] YES [ ] NO

Explain _____

_____

Physician's signature _____ Date _____