South Bend Community School Corporation
School Entry Physical Examination

TO BE COMPLETED BY PARENT (please print)

Student's Name _________________________ _______________________________ Birth date ___/___/_______
(Last) *(First)*

Sex: [ ] M [ ] F

Street address ____

Parent/Guardian name ____ Phone number ____________________

School ____ Grade ___________________

Check health conditions below that affect your child:

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

HAS YOUR CHILD BEEN SCREENED FOR LEAD? (Yes/No) *If no, SBCSC requires a lead screening for* ***children 6 and under*** *prior to school enrollment! Ask your health care provider or contact the St. Joseph County Health Department for information about lead screening @* ***574-235-9750, ext.7923***

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

____

List medication(s) your child is taking regularly:

____

Parent/Guardian Signature: ____ **Date: ______________**

TO BE COMPLETED BY HEALTHCARE PROVIDER (please print)

Date of Exam: _______________ HT ______ WT ______ B/P _________

	NORM.	*ABNORM.*	*REMARKS*
Eyes			Vision: RT LT
ENT			
Lungs			
Heart			
Abdomen			
Hernia			
Extremities			
Neuro			
Skin			

Test/Lab Results:

LEAD TEST: Date___/___/___ [ ] capillary or [ ] venous Result: __________

Urine *(if applicable)*: Alb ____ Sugar ____

Other conditions/disabilities:

____

____

Should child be restricted from any activities, including PE and recess? [ ] yes [ ] no

If yes, explain:

____

____

Healthcare Provider Name (Print): ____

Healthcare Provider Phone Number: ____

Healthcare Provider Signature: ________________________________ Date: ____________