KEY SCHOOL

Physical Examination (Key-Wee – 5th Grade)

Part I HISTORY FORM

Name: _____Date of birth: _____

Sex assigned at birth: _____ How does the child identify their gender? _____

Address: _____

Student's Routine Medical Provider	Student's Routine Dental Care Provider
Name: Address: Telephone: Date of last exam:	Name: Address: Telephone: Date of last exam:

List past and current medical conditions._____

_____

Has the child ever had surgery? If yes, list all past surgical procedures._____

_____

Medicine and supplements: List all current prescriptions, over-the-counter medicines, and supplements._____

_____

Does the child have any allergies? If yes, please list all the allergies (ie, medicines, pollens, food, stinging insects)._____

_____

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)			
Allergies (seasonal)			
Asthma or Breathing			
Behavioral or Emotional			
Birth Defect(s)			
Bladder			
Bleeding			
Bowels			
Cerebral Palsy			
Coughing			
Communication			
Developmental Delay			
Diabetes			
Ears or Deafness			
Eyes or Vision			
Feeding			
Head Injury			
Heart			
Hospitalization (When, Where)			
Lead Poison/Exposure (complete DHMH4620)			
Life Threatening Allergic Reactions			
Limits on Physical Activity			
Meningitis			
Mobility-Assistive Devices, if any			
Prematurity			
Seizures			
Sickle Cell Disease			
Speech/Language			
Surgery			
Other			

I give my permission for the Health Practitioner to complete Part II of this form. I understand it is for confidential use in meeting my child's health needs in child care/school. I attest that the information provided on this form is true and accurate to the best of my knowledge and belief.

Signature of Parent/Guardian: _____Date: _____

KEY SCHOOL

Physical Examination (Key-Wee - 5th Grade)
Part II PHYSICAL EXAM FORM

Name: _____Date of birth: _____
Date of examination: _____

1. Does the child have a diagnosed medical condition?
   No Yes
   _____
   _____

2. Does the child have a health condition which may require EMERGENCY ACTION while at school? (ie, seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem). If yes, please DESCRIBE. Additionally, please work with your School Nurse to develop an emergency plan.
   No Yes
   _____
   _____

3. Is the child on medication? If yes, indicate medication and diagnosis?
   No Yes
   _____
   _____

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a healthcare provider or a computer generated immunization record must be provided.

EXAMINATION			
Height		Weight	
BP	/	Pulse	
Lead Test Indicated: DHMH 4620 ☐ Yes ☐ No	Test #1:	Date:	/ Test #2 Date:

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/Orthopedic	☐	☐	☐
Cardiac/Murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐

Physical Examination (Key-Wee - 5th Grade)
Part II PHYSICAL EXAM FORM

ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunosufficiency	☐	☐	☐	Other:	☐	☐	☐
REMARKS: (Please explain any abnormal findings)							

Name of physician (print/type) _____ Date _____

Signature of physician _____