



HEALTH SERVICES DEPARTMENT

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 _____ Home phone _____

Check health conditions below that affect your child.

- | | | | |
|--------------------------------------------------|------------------------------------------|------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> cystic fibrosis | <input type="checkbox"/> heart condition | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> allergies | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disorder | <input type="checkbox"/> visual impairment |
| <input type="checkbox"/> asthma | <input type="checkbox"/> food allergy | <input type="checkbox"/> malignancy | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> bee sting allergy | <input type="checkbox"/> G.I. disorder | <input type="checkbox"/> neurological disorder | _____ |
| <input type="checkbox"/> chickenpox (date _____) | <input type="checkbox"/> hearing loss | <input type="checkbox"/> seizures | _____ |

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

List medication your child is taking regularly. _____

Parent/Guardian signature _____ 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 If yes, explain.

Physician's signature _____ Date _____