



Last _____ First _____ Middle _____	<b>Birth Date</b> Month/Day/ Year	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID</b>
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> <small>(Food, drug, insect, other)</small>	Yes No	List:	<b>MEDICATION</b> (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No		Hospitalizations? When? What for?	Yes No	
Birth defects?	Yes No		Surgery? (List all.) When? What for?	Yes No	
Developmental delay?	Yes No		Serious injury or illness?	Yes No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Diabetes?	Yes No		TB disease (past or present)?	Yes* No	
Head injury/Concussion/Passed out?	Yes No		Tobacco use (type, frequency)?	Yes No	
Seizures? What are they like?	Yes No		Alcohol/Drug use?	Yes No	
Heart problem/Shortness of breath?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Heart murmur/High blood pressure?	Yes No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			<b>Parent/Guardian Signature</b> _____ <b>Date</b> _____		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes No				
Bone/Joint problem/injury/scoliosis?	Yes No				

**PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA**

<b>HEAD CIRCUMFERENCE</b> if < 2-3 years old	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>BMI PERCENTILE</b>	<b>B/P</b>
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**DIABETES SCREENING** (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes  No  And any two of the following: **Family History** Yes  No   
**Ethnic Minority** Yes  No  **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes  No  **At Risk** Yes  No

**LEAD RISK QUESTIONNAIRE:** Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

**Questionnaire Administered?** Yes  No  **Blood Test Indicated?** Yes  No  **Blood Test Date** \_\_\_\_\_ **Result** \_\_\_\_\_

**TB SKIN OR BLOOD TEST** Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. [http://www.cdc.gov/tb/publications/factsheets/testing/TB\\_testing.htm](http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm).

**No test needed**  **Test performed**  **Skin Test: Date Read** / / **Result: Positive**  **Negative**  **mm** \_\_\_\_\_  
**Blood Test: Date Reported** / / **Result: Positive**  **Negative**  **Value** \_\_\_\_\_

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Normal	Comments/Follow-up/Needs
<b>Skin</b>			<b>Endocrine</b>		
<b>Ears</b>		Screening Result:	<b>Gastrointestinal</b>		
<b>Eyes</b>		Screening Result:	<b>Genito-Urinary</b>		LMP
<b>Nose</b>			<b>Neurological</b>		
<b>Throat</b>			<b>Musculoskeletal</b>		
<b>Mouth/Dental</b>			<b>Spinal Exam</b>		
<b>Cardiovascular/HTN</b>			<b>Nutritional status</b>		
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma	<b>Mental Health</b>		
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			<b>Other</b>		

**NEEDS/MODIFICATIONS** required in the school setting \_\_\_\_\_ **DIETARY** Needs/Restrictions \_\_\_\_\_

**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?  
If you would like to discuss this student's health with school or school health personnel, check title:  Nurse  Teacher  Counselor  Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?  
**Yes**  **No**  If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in \_\_\_\_\_ (If No or Modified please attach explanation.)

**PHYSICAL EDUCATION** Yes  No  Modified  **INTERSCHOLASTIC SPORTS** Yes  No  Modified

**Print Name** \_\_\_\_\_ (MD,DO, APN, PA) **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_