|  |  |  |
| --- | --- | --- |
| **Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Female\_\_\_\_\_ Male\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Medical and Health History** | | |
| History | Date | Comments |
| Allergies:  **(All Food Allergies will require a Dietary Modification Form)** |  | To Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  To Foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  To Latex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Epi-pen: Yes \_\_\_\_\_ No\_\_\_\_\_  **Please include allergy Plan** |
| Asthma:  **Please include Asthma Plan from Doctor** |  |  |
| Medications: |  |  |
| Illness, serious |  |  |
| Hospitalization/Surgery |  |  |
| Immunizations  **Attach IRIS Form** | * Up to date for school entry * Boosters needed: | |
| Other: |  | |

|  |  |  |
| --- | --- | --- |
| **Height\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_ Blood pressure\_\_\_\_\_\_\_\_\_\_**  **Vision: Both 20/\_\_\_\_\_ Right 20/\_\_\_\_\_ Left 20/\_\_\_\_\_** | | |
| **System** | **WNL** | **Comments:** |
| Skin |  |  |
| Eyes |  |  |
| Ears/Hearing |  |  |
| Mouth |  |  |
| Speech |  |  |
| Neck |  |  |
| Heart |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Genitourinary |  |  |
| Musculoskeletal |  |  |
| Neurologic |  |  |
| Emotional/social |  |  |
| Lead screening **(required)** |  | Date: \_\_\_\_\_\_\_\_\_  Results: |
| Dental screening  **(required)** |  | State Dental Form Required |
| Labs if indicated |  |  |
| **Health conditions requiring intervention/modification at school:** | | |
|  | | |
| **Physical Education Program: Full\_\_\_\_\_ Limited\_\_\_\_\_ None\_\_\_\_\_**  **Reason:** | | |

**Examined by (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician**