|  |
| --- |
|  **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**