History and Physical Examination Form

Child's full name: _____

Child's Date of Birth: _____

Parent/Guardian: Please complete this section:

Child's past history - please check and give date(s) if your child has had:

Allergies (specify) _____

Visual Difficulty _____

Asthma _____

Chicken Pox _____

Diabetes _____

Mumps _____

Physical Handicap (specify) _____

Seizures _____

Serious injury (specify) _____

Surgery (specify) _____

Measles _____

Other _____

Hospital preference _____

Did you child complete Preschool Screening in District 885? yes ___ no ____

If you selected NO, Please tell us what district your child was screened in._____

****If your child has not been screened, please contact Heather Knudson to schedule a screening appointment. (763)497-2688 Extension 92006**

Please use this space to elaborate any concerns or special needs you feel, your child may encounter at school

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Would you like to schedule an appointment with the school nurse? _____

Parent/Guardian Signature _____ Date _____

Best phone number to reach you at during the school day _____

*****Please have your Physician complete the OTHER side of this form.

PHYSICIAN: Please complete the section below:

Child's Name _____

Physical Examination:

Skin/Lymph_____ Mouth_____ Lungs_____
Neurological_____ Eyes_____ Throat_____
Abdomen_____ Speech_____ Ears_____
Neck_____ Nose_____ Genito-urinary_____
Nutrition_____ Heart_____ Orthopedic_____
Emotional_____
Further explanation necessary for any of the above:
_____
_____
Treatment plan/followup: _____
Ongoing therapies & medications (specify type & dose)
_____
_____
Height_____ Percentile_____
Weight_____ Percentile_____
Blood Pressure_____ Hemoglobin_____ Urine_____
Vision: R20/ L20/ with glasses?
Hearing: R _____ L _____
Immunizations given at this exam:
_____
Medications &/or treatments to be administered at school:
_____

Is a modified diet necessary: _____ If yes please specify_____
_____
Is there is a condition that may result in an emergency situation: yes ____ no _____
If yes, specify:
_____
Health Classification for School Program:
___ **Is in good health and able to participate in the entire school program.**
___ **There is a condition which may limit participation.**
(CIRCLE THOSE THAT APPLY AND EXPLAIN)
Classroom Activities Physical Education Competitive Sports

Is this limitation temporary or permanent? (Circle one)
If temporary, state time _____

Physician's Signature _____
Date of Exam _____ Telephone _____ Clinic name_____
Physician Name (print or type) _____