

Last			First			Middle			Birth Date Month/Day/ Year			Sex	School			Grade Level/ ID		
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER																		
ALLERGIES (Food, drug, insect, other)			Yes	No	List:			MEDICATION (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 _____																		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																		
Ear/Hearing problems?			Yes	No				Parent/Guardian Signature _____ Date _____										
Bone/Joint problem/injury/scoliosis?			Yes	No														
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA																		
HEAD CIRCUMFERENCE if < 2-3 years old			HEIGHT			WEIGHT			BMI			B/P						
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>																		
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 <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 . No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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															
Skin			Screening Result:			Endocrine												
Ears			Screening Result:			Gastrointestinal												
Eyes			Screening Result:			Genito-Urinary						LMP						
Nose						Neurological												
Throat						Musculoskeletal												
Mouth/Dental						Spinal Exam												
Cardiovascular/HTN						Nutritional status												
Respiratory			<input type="checkbox"/> Diagnosis of Asthma			Mental Health												
Currently Prescribed Asthma Medication:						Other												
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																		
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																		
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>						INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>												
Print Name _____ (MD,DO, APN, PA)						Signature _____						Date _____						
Address _____												Phone _____						