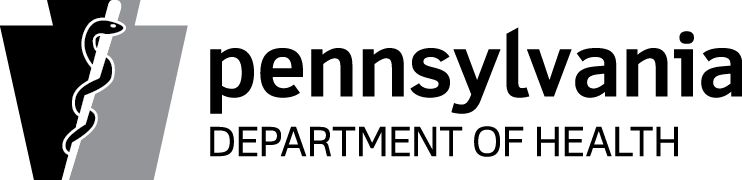
H511.336 (Rev. 9/2012) Page 1 of 4: STUDENT HISTORY

**Parent / Guardian / Student:**

**Complete page one of this form before student’s exam. Take completed form to appointment.**

**Private or School**



Bureau of Community Health Systems

Division of School Health

**PHYSICAL EXAMINATION**

#### OF SCHOOL AGE STUDENT

Student’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at time of exam\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female

|  |
| --- |
| Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the student have any allergies?  No  Yes (If yes, list specific allergy and reaction.)   Medicines  Pollens  Food  Stinging Insects |

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

|  |  |  |
| --- | --- | --- |
| **GENERAL HEALTH: *Has the student…*** | **YES** | **NO** |
| 1. Any ongoing medical conditions? If so, please identify:    Asthma  Anemia  Diabetes  Infection  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 2. Ever stayed more than one night in the hospital? |  |  |
| 3. Ever had surgery? |  |  |
| 4. Ever had a seizure? |  |  |
| 5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ? |  |  |
| 6. Ever become ill while exercising in the heat? |  |  |
| 7. Had frequent muscle cramps when exercising? |  |  |
| **HEAD/NECK/SPINE: *Has the student…*** | **YES** | **NO** |
| 8. Had headaches with exercise? |  |  |
| 9. Ever had a head injury or concussion? |  |  |
| 10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? |  |  |
| 11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling? |  |  |
| 12. Ever been unable to move arms or legs after being hit or falling? |  |  |
| 13. Noticed or been told he/she has a curved spine or scoliosis? |  |  |
| 14. Had any problem with his/her eyes (vision) or had a history of an eye injury? |  |  |
| 15. Been prescribed glasses or contact lenses? |  |  |
| **HEART/LUNGS: *Has the student...*** | **YES** | **NO** |
| 16. Ever used an inhaler or taken asthma medicine? |  |  |
| 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply:  Heart murmur or heart infection   High blood pressure  Kawasaki disease   High cholesterol  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)? |  |  |
| 19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **during** or **after** exercise? |  |  |
| 20. Had discomfort, pain, tightness or chest pressure during exercise? |  |  |
| 21. Felt his/her heart race or skip beats during exercise? |  |  |
| **BONE/JOINT: *Has the student...*** | **YES** | **NO** |
| 22. Had a broken or fractured bone, stress fracture, or dislocated joint? |  |  |
| 23. Had an injury to a muscle, ligament, or tendon? |  |  |
| 24. Had an injury that required a brace, cast, crutches, or orthotics? |  |  |
| 25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury? |  |  |
| 26. Had joints that become painful, swollen, feel warm, or look red? |  |  |
| **SKIN: *Has the student…*** | **YES** | **NO** |
| 27. Had any rashes, pressure sores, or other skin problems? |  |  |
| 28. Ever had herpes or a MRSA skin infection? |  |  |

|  |  |  |
| --- | --- | --- |
| **GENITOURINARY: *Has the student…*** | **YES** | **NO** |
| 29. Had groin pain or a painful bulge or hernia in the groin area? |  |  |
| 30. Had a history of urinary tract infections or bedwetting? |  |  |
| 31. **FEMALES ONLY:** Had a menstrual period?  Yes  No  If yes: At what age was her first menstrual period? \_\_\_\_\_\_  How many periods has she had in the last 12 months? \_\_\_\_\_\_  Date of last period: \_\_\_\_\_\_\_\_\_\_\_ | | |
| **DENTAL:** | **YES** | **NO** |
| 32. Has the student had any pain or problems with his/her gums or teeth? |  |  |
| 33. Name of student’s dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last dental visit:  less than 1 year  1-2 years  greater than 2 years | | |
| **SOCIAL/LEARNING: *Has the student…*** | **YES** | **NO** |
| 34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.? |  |  |
| 35. Been bullied or experienced bullying behavior? |  |  |
| 36. Experienced major grief, trauma, or other significant life event? |  |  |
| 37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends? |  |  |
| 38. Been worried, sad, upset, or angry much of the time? |  |  |
| 39. Shown a general loss of energy, motivation, interest or enthusiasm? |  |  |
| 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight? |  |  |
| 41. Used (or currently uses) tobacco, alcohol, or drugs? |  |  |
| **FAMILY HEALTH:** | **YES** | **NO** |
| 42. Is there a family history of the following? If so, check all that apply:   Anemia/blood disorders  Inherited disease/syndrome   Asthma/lung problems  Kidney problems   Behavioral health issue  Seizure disorder   Diabetes  Sickle cell trait or disease   Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply:    Brugada syndrome  QT syndrome   Cardiomyopathy  Marfan syndrome   High blood pressure  Ventricular tachycardia   High cholesterol  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning? |  |  |
| 45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)? |  |  |
| **QUESTIONS or CONCERNS** | **YES** | **NO** |
| 46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.) |  |  |

**I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.**

Signature of parent / guardian / emancipated student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2 of 4: PHYSICAL EXAM

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **STUDENT’S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION:** Yes No | | | | |
| Physical exam for grade:  K/1 6 11 Other | **CHECK ONE** | | | **\*abnormal findings / recommendations / referrals** |
| **normal** | **\*abnormal** | **defer** |
| Height: ( ) inches |  |  |  |  |
| Weight: ( ) pounds |  |  |  |  |
| BMI: ( ) |  |  |  |  |
| BMI-for-Age Percentile: ( ) % |  |  |  |  |
| Pulse: ( ) |  |  |  |  |
| Blood Pressure: (  **/**  ) |  |  |  |  |
| Hair/Scalp |  |  |  |  |
| Skin |  |  |  |  |
| Eyes/Vision Corrected |  |  |  |  |
| Ears/Hearing |  |  |  |  |
| Nose and Throat |  |  |  |  |
| Teeth and Gingiva |  |  |  |  |
| Lymph Glands |  |  |  |  |
| Heart |  |  |  |  |
| Lungs |  |  |  |  |
| Abdomen |  |  |  |  |
| Genitourinary |  |  |  |  |
| Neuromuscular System |  |  |  |  |
| Extremities |  |  |  |  |
| Spine (Scoliosis) |  |  |  |  |
| Other |  |  |  |  |

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| --- | --- | --- | --- |
| **tuberculin test** | **date applied** | **date read** | **result/follow-up** |
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| **MEDICAL CONDITIONS OR CHRONIC DISEASES which require medication, restriction of activity, or which may affect education** |
| (**Additional space on page 4)** |

|  |
| --- |
| Parent/guardian present during exam: Yes No  Physical exam performed at: Personal Health Care Provider’s Office School Date of exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_\_\_\_  Print name of examiner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print examiner’s office address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of examiner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD DO PAC CRNP  |

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| --- | --- | --- | --- | --- | --- |
| Page 3 of 4: IMMUNIZATION HISTORY |  |  |  |  | |
| health care providers: *Please photocopy immunization history from student’s record – OR – insert information below.* | | | | | |
|  | | | | | |
| **IMMUNIZATION EXEMPTION(S):**  Medical  Date Issued:\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Rescinded:\_\_\_\_\_\_\_\_\_\_\_  Medical  Date Issued:\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Rescinded:\_\_\_\_\_\_\_\_\_\_\_  Medical  Date Issued:\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Rescinded:\_\_\_\_\_\_\_\_\_\_\_  **NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption. | | | | | |
|  | | | | | |
| **VACCINE** | **DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization** | | | | |
| Diphtheria/Tetanus/Pertussis (child)  Type: DTaP, DTP or DT | 1 | 2 | 3 | 4 | 5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)  Type: Tdap or Td | 1 | 2 | 3 | 4 | 5 |
| Polio  Type: OPV or IPV | 1 | 2 | 3 | 4 | 5 |
| Hepatitis B (HepB) | 1 | 2 | 3 | 4 | 5 |
| Measles/Mumps/Rubella (MMR) | 1 | 2 | 3 | 4 | 5 |
| Mumps disease diagnosed by physician | Date:\_\_\_\_\_\_\_\_\_\_ | | | | |
| Varicella: Vaccine  Disease | 1 | 2 | 3 | 4 | 5 |
| Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella | 1 | 2 | 3 | 4 | 5 |
| Meningococcal Conjugate Vaccine (MCV4) | 1 | 2 | 3 | 4 | 5 |
| Human Papilloma Virus (HPV)  Type: HPV2 or HPV4 | 1 | 2 | 3 | 4 | 5 |
| Influenza  Type: TIV (injected)  LAIV (nasal) | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 |
| Haemophilus Influenzae Type b (Hib) | 1 | 2 | 3 | 4 | 5 |
| Pneumococcal Conjugate Vaccine (PCV)  Type: 7 or 13 | 1 | 2 | 3 | 4 | 5 |
| Hepatitis A (HepA) | 1 | 2 | 3 | 4 | 5 |
| Rotavirus | 1 | 2 | 3 | 4 | 5 |
| **Other Vaccines: (Type and Date)** | | | | | |
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Page 4 of 4: **ADDITIONAL COMMENTS (Parent / Guardian / Student / Health Care Provider)**

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