

**\*PARENT/GUARDIAN\*** to complete this page of the form Grade/Teacher \_\_\_\_\_

(Please circle School District) Monroe Juda Brodhead Albany Monticello New Glarus

\*Please complete the following health history as accurately as possible as you are waiting for your child's appointment. This information will assist both the physician and the school nurse to meet your child's needs at school.

STUDENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Please circle yes or no for those diseases that apply to immediate family, which includes the child's siblings, parents, grandparents, aunts, uncles.

Cancer	Yes	No	Sudden Death	Yes	No
Tuberculosis	Yes	No	Asthma	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No
Heart Disease	Yes	No	Elevated Blood Pressure	Yes	No
Depression/Mental Illness	Yes	No	Substance/Drug Abuse	Yes	No

**STUDENT HEALTH HISTORY** \*Please circle yes or no if your child does have or has suffered from any of the following:

Diabetes	Yes	No	Seizures	Yes	No
Asthma (Triggers?)	Yes	No	Neurological	Yes	No
Allergies (food, medications, environment)	Yes	No	Heart Conditions	Yes	No
Hospitalizations/Surgeries	Yes	No	Injuries/Burns/Fractures	Yes	No
Genetic/Congenital	Yes	No	Menstrual Difficulties	Yes	No
Hearing Difficulties	Yes	No	Bowel/Bladder concerns	Yes	No
Date of last Dental exam	Month	Year	Date of Last eye exam	Month	Year

If you answered **YES** to any of the above, please give a brief summary: \_\_\_\_\_  
 \_\_\_\_\_

Does your child take any prescription or over the counter medications? Yes No

Please list all medications and indicate why the child is taking it (use separate sheet of paper if needed) and whether they are taken at home, at school or both:  
 \_\_\_\_\_

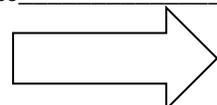
Does your child presently wear glasses or contacts? Yes No Eye Doctor's Name: \_\_\_\_\_

Please list any other information you feel is important to your child's health: \_\_\_\_\_

This form is complete and accurate to the best of my knowledge. By signing this form, I give permission to share my child's health information and immunization records with the Wisconsin Immunization Registry (WIR), with my immunization providers and with my child's school district to maintain the most accurate records. Check here if you do not give your permission to share this info.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**OVER for Physician's side of form for Physical Exam**



# SCHOOLS OF GREEN COUNTY –PHYSICAL FORM

*THIS SIDE TO BE COMPLETED BY YOUR CHILD'S HEALTHCARE PROVIDER*

Temp:	Pulse:	Resp:	BP:	Height:	Weight:	BMI:	Weight Management Plan: Yes or No
Vision	Right:	Left:	Referral : Yes or No	Other:			
Hearing	Right:	Left:	Referral : Yes or No	Acanthosis Nigricans Yes or No			

## PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal
SKIN			LUNGS		
HEAD			HEART		
EYES			ABDOMEN		
EARS			NEURO, MUSCULAR, BONES		
NOSE			SPINE/SCOLIOSIS		
THROAT/NECK			GENITALIA, LMP:		
TEETH Referral needed?			ENDOCRINE		

**Please describe any abnormal findings:**

**SIGNIFICANT LAB RESULTS:**

**IMMUNIZATION HISTORY** Immunizations are up to date? Yes or No Chicken Pox Illness Date: \_\_\_\_\_

- PLEASE attach copy of PROVIDER IMMUNIZATION RECORD or WIR copy to this form

**ASSESSMENT:** (Synopsis, health promotion, description of abnormal findings)

- Healthy Child ~This child is able to participate in all activities.
- This child has these restrictions: \_\_\_\_\_

**PLAN:** (Treatment, education, counseling, referrals): \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_