



Last _____ First _____ Middle _____ Birth Date _____ Sex _____ School _____ Grade Level/ ID _____ Month/Day/ Year
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES?</b> (Food, Drug, Insect, other)	Yes No	List: _____	<b>MEDICATION</b> (Prescribed or taken on a regular basis)	Yes No	List: _____
Diagnosis of asthma?	Yes No	Yes No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No	Yes No	Hospitalizations? When? What for?	Yes No	
Birth defects?	Yes No	Yes No	Surgery? (List all.) When? What for?	Yes No	
Developmental delay?	Yes No	Yes No	Serious injury or illness?	Yes No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No	Yes No	TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Diabetes?	Yes No	Yes No	TB disease (past or present)?	Yes* No	
Head injury/Concussion/Passed out?	Yes No	Yes No	Tobacco use (type, frequency)?	Yes No	
Seizures? What are they like?	Yes No	Yes No	Alcohol/Drug use?	Yes No	
Heart problem/Shortness of breath?	Yes No	Yes No	Family history of sudden death before age 50? (Cause?)	Yes No	
Heart murmur/High blood pressure?	Yes No	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	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 _____			<b>Parent/Guardian</b>		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			<b>Signature</b>		<b>Date</b>
Ear/Hearing problems?	Yes No	Yes No			
Bone/Joint problem/injury/scoliosis?	Yes No	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
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)</b> BMD>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"/>				
<b>LEAD RISK QUESTIONNAIRE:</b> 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	
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> .				
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	Normal	Comments/Follow-up/Needs
Skin			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:  
 Quick-relief medication (e.g. Short Acting Beta Agonist)  
 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:  Nurse  Teacher  Counselor  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  No  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  No  Modified  **INTERSCHOLASTIC SPORTS** Yes  No  Modified

Print Name \_\_\_\_\_ (MD, DO, APN, PA) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_