

Fishers Island School

Health Physical Examination Form

Student Name		Sex		DOB:	
Grade:		Date Entered:		Previous School	
Parent/Guardian					
Address					
Home Phone:		Work Phone:			
Cell Phone:					

To Be Completed by Health Care Provider

Medical History

Does the student have a past or present medical history of the following: (Circle those existing conditions)

		Reason	Date	Place
Asthma	Vision Problems			
Allergies	Hearing Problems			
Seizures	Speech Problems			
Diabetes	Hospitalizations			
Cancer	Surgery			
Tuberculosis	Serious Illness			
Orthopedic Problems	Serious Accidents			
	Other Limitations			
Congenital Heart Disease				

Family History (Circle those existing):

Asthma Allergies Cardiovascular Disease Seizures Diabetes

Cancer Other _____

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Student Name:					DOB	
Physical Exam						
Height:		Weight:		Blood Pressure:		
General Appearance (nutritional status):						
NL	AB		NL	AB		
		HEENT				Cardiovascular
		Dental				Abdomen
		Neck				Genitourinary
		Lymph				Extremities
		Lungs				Back
		Skin				Neurologic
		Psychological				Language
		Behavioral				Fine/Gross Motor
Describe Abnormalities:						
Screening Tests:						
		Date/Result				Date/Result
Hematocrit			Hearing			
Hemoglobin			Audio/Sweep			
Urinalysis			Threshold			
Vision:						
	Date	Far	Near			Color
Right						
Left						
Both						
TB Mantoux						
	Date:	Blood TB Test	CXR	BCG	INH	
PPD Planted	Date		Date	Date	Date	
Read		Name	NL	Yes	Yes	
Neg. mm		Pos.	AB	No	No	
Pos. mm		Neg.	N/A			
Lead:						
	Date					
If at risk, venous screening date:						
Risk questionnaire:						
	No Risk	Risk	Result:			

Please attach documentation of the following:
DTap, OPV or IPV, MMR, Hepatitis B, HIB, Varicella

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Asthma

In the past 12 months, has the child had any of the following symptoms?

Wheezing/whistling in chest?	Y/N
Coughing with exercise?	Y/N
Cough at night w/o cold	Y/N
No symptoms	None

In the past 12 months, has child taken any medicines for these symptoms? Y/N

In the past 12 months, has the child made an urgent visit to a doctor or
Emergency dept. for asthma, or other breathing problems? Y/N

Types of Problems

Well Child Y/N

1. _____

2. _____

3. _____

Recommendations

Full physical activity Y/N

Restrictions (specify below)

Date of Examination:

Physician Signature

Address: _____

Physician Name

Telephone: _____

Consent for Medication and Emergency

Permission hereby given that my child may receive upon request:

Tylenol Y/N Advil Y/N

Special Instruction:

In case of medical emergency, school personnel may accompany my child to doctor's office, or hospital.

Parent Signature

Date: _____