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? Child wakes during night coughing?	☐ Yes ☐ No ☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Birth defects?	☐ Yes ☐ No		Hospitalizations? When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		Surgery? (List all.) When? What for?	☐ Yes ☐ No	
Diabetes?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department.
Seizures? What are they like?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Dizziness or chest pain with exercise?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	☐ Yes ☐ No		Information may be shared with appropriate personnel for health and educational purposes. **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☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

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 ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **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 ☐ **Test performed ☐** **Skin Test: Date Read** **Result: Positive ☐ Negative ☐** **mm**
Blood Test: Date Reported **Result: Positive ☐ Negative ☐** **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		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

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**