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



## Bureau of Community Health Systems

## Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

## PARENT / GUARDIAN / STUDENT:

Complete page one of this form <u>before</u> student's exam. Take completed form to appointment.

Division of School Health	арронинени.	арропшпенс.					
Student's name			Today's date				
Date of birth	Age at tii	me of ex	exam Gender:   Male  Female				
Medicines and Allergies: Please list all prescription and over-	-the-cou	inter medicines and supplements (herbal/nutritional) the student is currently taking:					
Does the student have any allergies? ☐ No ☐ Yes (If yes, lis	t specifi	c allerg	y and reaction.)		<del></del>		
□ Medicines □ Pollens			□ Food □ Stinging Insects				
Complete the following section with a check mark in the	YES or	NO co	lumn; circle questions you do not know the answer to.				
GENERAL HEALTH: Has the student	YES	NO	GENITOURINARY: Has the student	YES	NO		
Any ongoing medical conditions? If so, please identify:			29. Had groin pain or a painful bulge or hernia in the groin area?				
☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other			30. Had a history of urinary tract infections or bedwetting?	Yes [	□ No		
2. Ever stayed more than one night in the hospital?			31. <b>FEMALES ONLY:</b> Had a menstrual period?	Tes L	<b>□</b> 100		
3. Ever had surgery?			How many periods has she had in the last 12 months?				
4. Ever had a seizure?			Date of last period:				
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?			DENTAL:	YES	NO		
6. Ever become ill while exercising in the heat?			32. Has the student had any pain or problems with his/her gums or teeth?	<u> </u>			
7. Had frequent muscle cramps when exercising?			33. Name of student's dentist:	_			
HEAD/NECK/SPINE: Has the student	YES	NO	Last dental visit:  less than 1 year  1-2 years  greater than				
8. Had headaches with exercise?			SOCIAL/LEARNING: Has the student	YES	NO		
9. Ever had a head injury or concussion?			34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?				
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			35. Been bullied or experienced bullying behavior?				
11. Ever had numbness, tingling, or weakness in his/her arms or legs			36. Experienced major grief, trauma, or other significant life event?				
after being hit or falling?			37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?				
12 Ever been unable to move arms or legs after being hit or falling?			38. Been worried, sad, upset, or angry much of the time?				
13 Noticed or been told he/she has a curved spine or scoliosis?			39. Shown a general loss of energy, motivation, interest or enthusiasm?				
14 Had any problem with his/her eyes (vision) or had a history of an eye injury?			40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?				
15 Been prescribed glasses or contact lenses?			41. Used (or currently uses) tobacco, alcohol, or drugs?				
HEART/LUNGS: Has the student	YES	NO	FAMILY HEALTH:	YES	NO		
16 Ever used an inhaler or taken asthma medicine?				1123	140		
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 ☐ Other:			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				
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?			☐ Diabetes ☐ Sickle cell trait or disease  Other				
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded <b>DURING</b> or <b>AFTER</b> exercise?			43. Is there a family history of any of the following heart-related problems? If so, check all that apply:				
20 Had discomfort, pain, tightness or chest pressure during exercise?			☐ Brugada syndrome ☐ QT syndrome	ł			
21. Felt his/her heart race or skip beats during exercise?			☐ Cardiomyopathy ☐ Marfan syndrome	ł			
BONE/JOINT: Has the student	YES	NO	☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other				
22 Had a broken or fractured bone, stress fracture, or dislocated joint?			44. Has any family member had unexplained fainting, unexplained				
23. Had an injury to a muscle, ligament, or tendon?			seizures, or experienced a near drowning?	ł			
24. Had an injury that required a brace, cast, crutches, or orthotics?			45. Has any family member / relative died of heart problems before age				
25 Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?			50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant				
26. Had joints that become painful, swollen, feel warm, or look red?			death syndrome)?	VEO	NO		
SKIN: Has the student	YES	NO	QUESTIONS OR CONCERNS	YES	NO		
27. Had any rashes, pressure sores, or other skin problems?			46. Are there any questions or concerns that the student, parent or quardian would like to discuss with the health care provider? (If				
28. Ever had herpes or a MRSA skin infection?			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
•	~	•	

STUDENT'S HEA	STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes  No					
			СН	ECK O	NE	
Physical exam for	grade:			Ι		
K/1 □ 6 □ 1	11 🗆	Other	NORMAL	*ABNORMAL	8	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
			NOR	*ABI	DEFER	
Height: (	) in	nches				
Weight: (	) p	ounds				
BMI: (	)					
BMI-for-Age Percenti	le: (	) %				
Pulse: (	)					
Blood Pressure: (	/	)				
Hair/Scalp						
Skin						
Eyes/Vision	Correcte	ed 🗆				
Ears/Hearing						
Nose and Throat						
Teeth and Gingiva						
Lymph Glands						
Heart						
Lungs						
Abdomen						
Genitourinary						
Neuromuscular Syste	em					
Extremities						
Spine (Scoliosis)						
Other						
TUBERCULIN TEST	DATE	APPLIED	D/	ATE RE	AD	RESULT/FOLLOW-UP
(Additional space on		TIONS OR	CHROI	NIC DIS	SEASE	S WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
(Additional Space on	page 4)					
Parent/guardian pr	esent dı	uring exa	m: Ye	es 🗆		No □
Physical exam performed at: Personal Health Care Provider's Office School Date of exam20						
Print name of exam	Print name of examiner					
Print examiner's of	ffice add	lress				Phone
Signature of examiner						MD □ DO □ PAC □ CRNP □

## STUDENT NAME:

HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record – OR – insert information below.

IMMUNIZATION EXEMPTION(S):								
Medical ☐ Date Issued: Rea	son:		Date Rescinded:	Date Rescinded:				
		: Date Rescinded:						
NOTE: The parent/guardian must provide a								
		e conserver a congre	р					
VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization							
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT			·					
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			
	1	2	3	4	5			
Influenza	6	7	8	9	10			
Type: TIV (injected) LAIV (nasal)		10	13	14				
		12	10	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 Vac	cines: (Type and I	Date)					

Page 4 of 4: ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER) STUDENT NAME: