

PHYSICAL FORM

East Metro Integration District 6067

Name _____ Date of Birth _____ Sex M F
 Address _____ City _____ State _____ Zip _____ Phone _____
 Name of Mother _____ Name of Father _____

Health History

To be completed by parent and physician/nurse practitioner

- | | |
|--|---|
| <input type="checkbox"/> Lazy eye
<input type="checkbox"/> Frequent ear infections
<input type="checkbox"/> Snores at night
<input type="checkbox"/> Mouth breather
<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Bowel/bladder problems
<input type="checkbox"/> Attention difficulties
<input type="checkbox"/> Speech difficulties
<input type="checkbox"/> Behavior difficulties
<input type="checkbox"/> Seizure condition
<input type="checkbox"/> Tics
<input type="checkbox"/> HIV
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Motor difficulties
<input type="checkbox"/> CMV | <input type="checkbox"/> Allergies, Please specify below
Food _____
Medication _____
Insect _____
Environmental _____
Contact _____
Other _____ |
|--|---|

- Complicated pregnancy/premature _____ weeks
- Takes daily medication: Specify:

- Has been seen by a specialist:

Specialist's Name _____ Date of last visit _____

I hereby give permission to school authorities to contact my child's doctor for further information as necessary.

 Parent/Guardian Signature _____ Date _____

Physical Examination

To be completed by physician/nurse practitioner

Date of examination _____

_____ Ht	_____ Wt	_____ TB test	_____ Date	_____ Result
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General Appraisal

_____ Ht _____ WT _____ Eyes _____ Vision _____ Ears _____ Hearing _____ Nose _____ Teeth _____ Palate _____ Lead Exposure	_____ Hgb _____ Urinalysis _____ B/P _____ Orthopedic _____ Scoliosis _____ Lungs _____ Abd _____ Skin _____ Heart _____ Allergies
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Areas of Concern:

Immunizations given today:

Restrictions to diet/activity:

 Health Provider Signature _____ Date _____

Phone _____

Address _____