INDEPENDENT SCHOOL DISTRICT 279 OSSEO AREA SCHOOLS

HISTORY AND PHYSICAL EXAMINATION FORM

PARENT OR GUARDIAN: Please complete this section prior to seeing physician.

Student's Name: _____ Birthdate _____
(Last) (First) (Initial)

Parent/Guardian _____

Grade_____ Age _____ Date _____ School (If Known) _____

PAST HISTORY

Please CHECK (4) if your child has ever had -

Red Measles		Other (Specify)	
German Measles		Serious Accident:	
Epilepsy		Surgery (Specify)	
Mumps		Allergies (Specify)	
Asthma Heart Disease		For kindergarten age and under . .	
Diabetes		At what age did your child:	
Scarlet Fever		Sit Alone	
Rheumatic Fever		Walk Alone	
Chicken Pox		Talk Words	
High Temperature		Talk Sentences	
Convulsions		Bladder Train	
		Bowel Train	

CURRENT HISTORY

Please CHECK (4) if you have noticed any of these problems recently -

Poor Vision		Frequent Sore Throat	
Dizziness		Joint Pains	
Fainting Spells		Bladder Problems	
Abdominal Pain		Bowel Problems	
Allergy		Bleeds Easily	
Persistent Cough		Clumsy	
Speech Difficulty		Thumb Sucking	
Physical Handicap		Asthma	
Trouble Sleeping		Tires Easily	
Hard of Hearing		Other (Specify)	
Shortness of Breath			
Ear Trouble (3 or more times a year)			
Strep Throat (3 or more times a year)			

PARENT/GUARDIAN SIGNATURE DATE

PHYSICIAN: Please complete this section.

Tests Indicate: Normal (N) Abnormal (Ab) If Abnormal include comments below N/Ab	Measurements Give Exact Value
	Blood Pressure
	Height
	Weight
Hemoglobin/Hematocrit	Vision: R20/ L/20
Urine	Hearing: R _____ L _____ w hearing aid Yes No
Other (Specify)	Was standardized developmental screening administered? Yes No Results _____

Ongoing Therapies and Medications - Specify Type and Dose

Immunizations given at this exam _____

Examination - Indicate Normal (N) or Abnormal (Ab). If Abnormal include comments below.

	N/Ab		N/Ab
Skin/Lymph		Lungs	
Eyes		Abdomen	
Ears		Genito-urinary	
Nose		Orthopedic-feet	
Mouth		Orthopedic-spine	
Throat		Neurological	
Neck		Speech	
Heart		Other (Specify)	

There is a condition that may result in an Emergency situation.
Yes ____ No ____ If yes, specify _____

PROBLEMS AS INDICATED ABOVE RECOMMENDATIONS FOR SCHOOL

_____

HEALTH CLASSIFICATION FOR SCHOOL PROGRAM

_____ 1. Is in excellent health and able to participate in the entire school program.
_____ 2. There is a condition which may limit participation. (Circle any or all that apply)
Classroom Activities Physical Education Competitive Sports (State reason and recommendation above.)
Is the above classification temporary? (Circle One) YES NO If YES, state time _____

Physician's Signature _____ Date of Examination _____ Phone _____

Physician's Name _____ Address _____
(Please Print or Type)

The information requested will be used to provide a background for making educational decisions regarding your child. Although physical exams are not mandated by law, we encourage exams prior to grades K, 4, 7. This information is available to school personnel when necessary in working with your son/daughter. Its use and/or release is subject to School Board Policy 515 and the Minnesota Data Privacy Act.