



**Return form to your child's school prior to the first day of entrance**

**Parent/Guardian Complete this top portion:**

School Name \_\_\_\_\_

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle)  M  F Birth Date \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_ Home Phone \_\_\_\_\_

Significant Past Health History or present illness: \_\_\_\_\_

Health History

	Yes	No	Remarks
Chronic Recurrent Illness			
Serious Injury (bone, joint, head)			
Hospitalizations/ER visits			
Asmtha			
Diabetes			
Seizures			

	Yes	No	Remarks
Headaches			
Vision Impairment			
Hearing Impairment			
Kidneys			
Fainting			
Recurrent Skin Problem			
Other			

**Physical Health Examination (examining practitioner to complete this section):**

Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected:  Yes  No Hearing by 20db audiometry: R \_\_\_\_\_ L \_\_\_\_\_

Hearing Subjective questions (for 7th grade) Pass \_\_\_\_\_ Fail \_\_\_\_\_ If Fail: Audiometry R \_\_\_\_\_ L \_\_\_\_\_

Height \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. BMI \_\_\_\_\_ % BMI \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

Allergies \_\_\_\_\_ Current medications \_\_\_\_\_

	Normal	Abnormal	Remarks
Eye			
cover test			
corneal reflection			
ENT			
Dental			
Heart			
Lungs			
Abdomen			

	Normal	Abnormal	Remarks
Genitourinary			
Skin			
Extremities			
Musculoskeletal			
Spine/scoliosis			
Nutritional status			
Emotional status			

**Sports/Physical Education approved?**  Yes  No Limitations: \_\_\_\_\_

For 7th Grade: Competitive inter school sports approved?  Yes  No Limitations: \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Exam Date \_\_\_\_\_

Clinic Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax # \_\_\_\_\_