Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

**GENERAL HEALTH: Has the student...**

1. Any ongoing medical conditions? If so, please identify:
   - Diabetes
   - Anemia
   - Asthma
   - Infection
   - Other ______

2. Ever stayed more than one night in the hospital?

3. Ever had surgery?

4. Ever had a seizure?

5. Ever had surgery?

6. Ever become ill while exercising in the heat?

7. Ever had a broken or fractured bone, stress fracture, or dislocated joint?

8. Ever had headaches with exercise?

9. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

10. Ever been unable to move arms or legs after being hit or falling?

11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?

12. Ever had missing, or had a painful bulge or hernia in the groin area?

13. Ever had groin pain or a history of urinary tract infections or bedwetting?

14. Ever had herpes or a MRSA skin infection?

15. Ever been unable to move arms or legs after being hit or falling?

16. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

17. Ever had a heart test? (For example, ECG/EKG, echocardiogram?)

18. Ever had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded during or after exercise?

19. Ever had a head injury or concussion?

20. Ever had a heart or chest pain during exercise?

21. Felt his/her heart race or skip beats during exercise?

22. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

23. Ever had a history of being born without a kidney, eye, a testicle (male), spleen, or any other organ?

24. Ever had a history of urinary tract infections or bedwetting?

25. Ever had a heart or chest pain during exercise?

26. Ever had a history of urinary tract infections or bedwetting?

**HEAD/NECK/SPINE: Has the student...**

27. Ever had a head injury or concussion?

28. Ever had surgery?

29. Ever had a head injury or concussion?

30. Ever had surgery?

31. EVER HAD AN ALLERGY OR SKIN PROBLEM?

32. Ever had surgery?

33. Ever had any rashes, pressure sores, or other skin problems?

34. Ever had surgery?

35. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

36. Ever had surgery?

37. Ever had surgery?

38. Ever had surgery?

39. Ever had surgery?

40. Ever had surgery?

41. Ever had surgery?

**GENITOURINARY: Has the student...**

42. Ever had surgery?

43. Ever had surgery?

44. Ever had surgery?

45. Ever had surgery?

**DENTAL:**

46. Ever had surgery?

47. Ever had surgery?

48. Ever had surgery?

49. Ever had surgery?

**SOCIAL/LEARNING:**

50. Ever had surgery?

51. Ever had surgery?

52. Ever had surgery?

53. Ever had surgery?

**FAMILY HEALTH:**

54. Ever had surgery?

55. Ever had surgery?

56. Ever had surgery?

57. Ever had surgery?

58. Ever had surgery?

59. Ever had surgery?

60. Ever had surgery?

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 HEALTH HISTORY

**REVIEWED PRIOR TO PERFORMING EXAMINATION:**
- Yes [ ]
- No [ ]

### Physical Exam for Grade:
- K/1 [ ]
- 6 [ ]
- 11 [ ]
- Other [ ]

### CHECK ONE
- [ ] NORMAL
- [ ] ABNORMAL
- [ ] DEFER

### *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS*

<table>
<thead>
<tr>
<th>CHECK</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>DEFER</th>
</tr>
</thead>
</table>

### Physical Exam Details:
- **Height:** ( ) inches
- **Weight:** ( ) pounds
- **BMI:** ( )
- **BMI-for-Age Percentile:** ( ) %
- **Pulse:** ( )
- **Blood Pressure:** ( / )

### Health Assessments:
- **Hair/Scalp**
- **Skin**
- **Eyes/Vision**
- **Corrected** [ ]
- **Ears/Hearing**
- **Nose and Throat**
- **Teeth and Gingiva**
- **Lymph Glands**
- **Heart**
- **Lungs**
- **Abdomen**
- **Genitourinary**
- **Neuromuscular System**
- **Extremities**
- **Spine (Scoliosis)**
- **Other**

### TUBERCULIN TEST
- **DATE APPLIED**
- **DATE READ**
- **RESULT/FOLLOW-UP**

### MEDICAL CONDITIONS OR CHRONIC DISEASES

(Additional space on page 4)

### Parent/guardian present during exam:
- Yes [ ]
- No [ ]

### Physical Exam performed at:
- Personal Health Care Provider's Office [ ]
- School [ ]
- Date of exam: 20

### Print name of examiner

### Print examiner's office address

### Phone

### Signature of examiner

[ ] MD
[ ] DO
[ ] PAC
[ ] CRNP
**IMMUNIZATION EXEMPTION(S):**

<table>
<thead>
<tr>
<th>Medical</th>
<th>Date Issued</th>
<th>Reason</th>
<th>Date Rescinded</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Polio Type: OPV or IPV</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Mumps disease diagnosed by physician</td>
<td>Date:</td>
</tr>
<tr>
<td>Varicella: Vaccine</td>
<td>Disease</td>
</tr>
<tr>
<td>Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Meningococcal Conjugate Vaccine (MCV4)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Human Papilloma Virus (HPV) Type: HPV2 or HPV4</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Influenza Type: TIV (injected)</td>
<td>LAIV (nasal)</td>
</tr>
<tr>
<td>Haemophilus Influenzae Type b (Hib)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

**Other Vaccines: (Type and Date)**