St Elizabeth School Physical Examination
Part I- Health Assessment to be completed by parent or Guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr)	Sex (M/F)	Name of School St Elizabeth School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child had any problem with the following? Please check.

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning			
Learning Problems/ Disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?

☐ No ☐ Yes Name(s) of Medications:

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

☐ No ☐ Yes Treatment:_____

Does your child require any special procedures? (catherization, etc.)

☐ No ☐ Yes Procedure: _____

Parent/Guardian Signature: _____ Date: _____

St Elizabeth School Physical Examination
Part II- Health Assessment to be completed ONLY Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr)	Sex (M/F)	Name of School St Elizabeth School	Grade

1. Does the child have a diagnosed medical condition?

☐No ☐Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is here at school? (e.g. seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally please work with your school nurse to develop an emergency plan.

☐ No ☐ Yes _____

_____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity	☐	☐
Eyes				Behavior/Adjustment	☐	☐
ENT				Development	☐	☐
Dental				Hearing	☐	☐
Respiratory				Immunodeficiency	☐	☐
Cardiac				Lead Exposure/Elevated Lead	☐	☐
GI				Learning Disabilities/Problems	☐	☐
GU				Mobility	☐	☐
Musculoskeletal/Orthopedic				Nutrition	☐	☐
Neurological				Physical Illness/Impairment	☐	☐
Skin				Psychological	☐	☐
Endocrine				Speech/ Language	☐	☐
Psychosocial				Vision	☐	☐
				Other	☐	☐

REMARKS: (Please explain any abnormal findings.)

4. Record of Immunizations- DHMH 896 is required to be completed by a healthcare provider or a computer generate immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. Please attach list if necessary.

☐ No ☐ Yes

A medication administration form must be completed for medication administration in school.

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction. ☐No ☐Yes _____

7. Screenings	Results	Date Taken
Heart Rate		
Blood Pressure		
Height		
Weight		
BMI Percentile		
Lead Test (optional)		

St Elizabeth School Physical Examination
Part II- Health Assessment to be completed ONLY Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr)	Sex (M/F)	Name of School St Elizabeth School	Grade

(Child's Name) _____ has had a complete physical examination and has

☐ no evident problem that may affect learning or full school participation ☐ problems noted above

The St. Elizabeth School playground has a padded floor and various pieces of equipment, including two slides, two spinning elements, monkey bars, and a music-making unit which is mounted to the floor.

Please check the appropriate boxes below

☐ Allow access to all of the equipment

Do not allow use of the following equipment:

☐ Large spinner ☐ Small spinner ☐ Slides ☐ Monkey bars ☐ Raised platform

□ Other (please describe any additional prohibitions or concerns):_____
_____
_____
_____

Additional Comments Or Health Concerns:

Physician/Nurse Practitioner (type or print)	Phone No.	Physician/Nurse Practitioner Signature	Date