Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	List:	
Diagnosis of asthma?	Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Child wakes during night coughing?	Yes No						
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading).				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature**			**Date**
Bone/Joint problem/injury/scoliosis?	Yes No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____

Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.

HISTORIAL MÉDICO - PARA SER COMPLETADO Y FIRMADO POR PADRES / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)				**MEDICINAS** (Anote todas las recetadas o tomadas con regularidad.)			
¿Tiene diagnóstico de asma? ¿Despierta el niño tosiendo en la noche?	Sí Sí	No No		¿Tiene pérdida de Funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí	No	
¿Tiene defectos de nacimiento?	Sí	No		¿Ha sido hospitalizado? ¿Cuándo? ¿Por Qué?	Sí	No	
¿Tiene retrasos del desarrollo?	Sí	No					
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí	No		¿Ha atendido cirugía? (anótelas todas) ¿Cuándo? ¿Para Qué?	Sí	No	
¿Tiene diabetes?	Sí	No		¿Ha tendido heridas graves o enfermedades?	Sí	No	
¿Tiene heridas en la cabeza / golpe / desmayo?	Sí	No		¿Prueba positiva de TB (Pasado o Presente)?	Sí*	No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? ¿Cómo se manifiestan?	Sí	No		¿Enfermedad de TB (Pasado o Presente)?	Sí*	No	
¿Tiene problemas cardiacos / No respira bien?	Sí	No		¿Usa tabaco (tipo, Frecuencia)?	Sí	No	
¿Tiene soplo en corazón / presión arterial alta?	Sí	No		¿Toma alcohol / drogas?	Sí	No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí	No		¿Historial de familiares de muerte repentina antes de los 50 años ? (¿Causa?)	Sí	No	
¿Problemas con los Ojos? ____ Lentes ··· Lentes de Contacto ··· Último Examen ____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)				Dental ··· Ganchos ··· Puente ··· Placas Otro			
¿Tiene problemas de oídos / No oye bien?	Sí	No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación. **Firma del Padre/Tutor** **Fecha**			
¿Tiene problemas de los huesos / articulaciones / heridas / escoliosis?	Sí	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

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DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes··· No··· And any two of the following: **Family History** Yes ··· No ···
Ethnic Minority Yes··· No ··· **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes··· No ··· **At Risk** Yes ··· No

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered ? Yes ··· No ··· **Blood Test Indicated?** Yes ··· No ··· **Blood Test Date** (Blood test required if resides in Chicago.)

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Skin Test: Date Read / / **Result: Positive** ··· **Negative** ··· **mm** _____

Blood Test: Date Reported / / **Result: Positive** ··· **Negative** ··· **Value** _____

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EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ··· **No** ··· If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ··· **No** ··· **Modified** ··· **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ··· **No** ··· **Limited** ···

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)