WISCONSIN CONFERENCE OF SEVENTH-DAY ADVENTISTS
ELEMENTARY SCHOOLS

PHYSICAL EXAMINATION & HEALTH HISTORY FORM

The following information is requested so the school and parent can work together to meet the physical, intellectual, and emotional needs of the child.

Child's Health History Date: ______________ Grade K 1 2 3 4 5 6 7 8 9 10 Date of Birth ____________

Child's Name: ____
Last First Middle

Address: ____
Street City State Zip

Child's Physician: ______________________________ Physician's Phone ________________________________

Physician's Address: ____
Street City State Zip

PAST ILLNESS – please check (x) those which your child has had below)

Measles __ Diabetes __ Chicken Pox __ Heart Disease __ Mumps __ Epilepsy __ Polio __
Small Pox __ Scarlet Fever __ Frequent colds (No. Per year) ___ Hay Fever or Asthma __

1. Please specify any other serious illness, operation or injury, and age when occurred: ____

____

2. Has your child been exposed to tuberculosis? Yes __ No __ If so, Year ___________

GENERAL HEALTH –

1. Does your child have any condition or illness that you feel the school should know about? Yes __ No __ If yes, please explain: ______

____

2. Does your child wear glasses or corrective lenses? Yes __ No __ If yes, last exam date: ___________________
3. Does your child have hearing difficulties? Yes __ No __ If yes, last exam date: _________________
4. Does your child have any allergies? Yes __ No __ If yes, what are they and how are they treated? ______________________________

5. Is there any special medical need you'd like the school to assist your child with during the school year? If yes, please specify: ________

____

Parent/Guardian Signature: ____________________________________

EXAMINATION RECORD TO BE FILLED OUT BY THE PHYSICIAN:

General appearance: __________ General nutrition: __________ Blood pressure: __________ Hearing (Audiometric): _____________
Tonsils & adenoids: __________ Other lab exam: _____________ Height: _________ Weight: _________ Posture: ________________
Feet: ________ Skin: ________ Abdomen: __________ Heart: _________ Genitals: ________ Hernia: ________ Pulse: _________
Vision (right eye): _________ Vision (left eye): _________ Thyroid: _______ Other glands: __________ Reflexes: ___________
Lungs: ____________ Emotional status: __________________________________ General Condition: __________________________

Is the student capable of carrying a full program of school works, including Physical Education? Yes __ No __ If no, please give reason and state limitations: ____

____

Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other?
Yes __ No __ If yes, explain ____

____

Is the student's immunization test up to date? Yes __ No __

(Child's name) ____________________________ has been examined by me and found free of disease and is physically and mentally able to participate in group activities.

Physician's Signature: __________________________________ Date: ________________________________