STRAFFORD SCHOOL HEALTH SERVICES
PHYSICAL EXAMINATION
(Filled out by Physician)

Student's Name: _____ Age:_____ D.O.B.:_____

Height _____ B/P _____ Vision: R _____ Hearing: R _____
Weight _____ L _____ L _____

History:

_____ Chicken Pox	____ Ear Infections	____ Kidney Disorders	____ Diabetes	____ Other
_____ Heart Disease	____ Seizures	____ Eczema	____ Pneumonia	
_____ Fractures	____ Asthma	____ Measles	____ TB	

Dates/Explain:_____
_____
_____

Medications: _____ for _____
_____ for _____
_____ for _____

Allergies: Medications_____
Foods_____
Environmental _____
Dietary Restrictions: _____

Date of last dental exam: _____ ***DENTIST name :*** _____

Exam:

_____ ENT	_____ Neck	_____ Abdomen	_____ Joints/ROM	
_____ Teeth/Gums	_____ Chest	_____ Spine	_____ Skin	
_____ Thyroid	_____ Heart	_____ CNS	_____ Genitalia	___ U/A
_____ Lymph Nodes	_____ Lungs	_____ Orthopedic		___ Hct/Hgb

Explain:_____
_____
_____

Is there any health concerns that the school nurse should be made aware of? _____
_____

This child's physical condition allows for:
_____ <u>FULL</u> participation in all physical activities and school sponsored sports.
_____ <u>NO</u> participation in any physical activities or school sponsored sports.
_____ <u>LIMITED</u> participation in all physical activities and <u>NO</u> school sponsored sports
Explain restrictions/limitations _____
_____

Physician's signature:_____ EXAM Date: _____
Printed name of physician: _____ TODAYS Date: _____
Address: _____
Phone: _____

***PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD**

STUDENT'S HEALTH HISTORY

(To be completed by a parent/guardian)

Dear Parent:
We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return to the health office.

Kathryn Cunningham RN

STUDENT:_____ **M / F** D.O.B. : _____
FATHER: _____ MOTHER: _____ GUARDIAN: _____
Step Father: _____ Step Mother: _____
SIBLINGS (ages): _____
With whom does the child live? _____ Birthplace:_____
How is healthcare provided for this student? ___ Insurance ___ NH Healthy Kids ___ Medicaid
___ Social Security Insurance ___ Other

		YES	NO
Has your child ever had an illness or injury that:	a) required him/her seek medical attention?	____	____
	b) lasted longer than a week?	____	____
	c) required hospitalization or an operation?	____	____
	d) is chronic? (i.e. Asthma, Diabetes, etc)	____	____
	e) required x-rays ?	____	____
Has your child had surgery or been hospitalized within this past year?		____	____
Has your child ever had any heart-related abnormality?		____	____
Has your child ever: a) been dizzy or passed out during or after exercise?		____	____
b) been unconscious or had a concussion?		____	____
c) had a seizure?		____	____
Does your child wear glasses or contact lenses?		____	____
Do you have any concerns regarding your child's' speech?		____	____
Does your child wear braces, bridges, or dental plates?		____	____

Please explain any 'YES' answers. _________
_____
_____

For girls: At what age did your daughter have her first menstrual period? _____

List all medications your child is presently taking and what the medication is for.

a) _____ for _____
b) _____ for _____
c) _____ for _____

***If your child requires medications for after-school activities, *you need* to supply the medication to the coach/activity advisor for administration.**

Do you have any concerns about your child's health at this time? _____
_____
_____

I give permission for my child's physician to release medical information regarding my child, to assist the Strafford School Nurse with the daily care of my child. ____Yes ____No

Parent/Guardian signature: _____ Date _____