PARENT/GUARDIAN ***to complete this page of the form*** **Grade/Teacher_____**

(Please circle School District) Monroe Juda Brodhead Albany Monticello New Glarus

***Please complete the following health history as accurately as possible as you are waiting for your child's appointment. This information will assist both the physician and the school nurse to meet your child's needs at school.**

STUDENT: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN: _____PHYSICIAN:_____

FAMILY MEDICAL HISTORY: Please circle yes or no for those diseases that apply to immediate family, which includes the child's siblings, parents, grandparents, aunts, uncles.

Cancer	Yes	No	Sudden Death	Yes	No
Tuberculosis	Yes	No	Asthma	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No
Heart Disease	Yes	No	Elevated Blood Pressure	Yes	No
Depression/Mental Illness	Yes	No	Substance/Drug Abuse	Yes	No

STUDENT HEALTH HISTORY *Please circle yes or no if your child does have or has suffered from any of the following:

Diabetes	Yes	No	Seizures	Yes	No
Asthma (Triggers?)	Yes	No	Neurological	Yes	No
Allergies (food, medications, environment)	Yes	No	Heart Conditions	Yes	No
Hospitalizations/Surgeries	Yes	No	Injuries/Burns/Fractures	Yes	No
Genetic/Congenital	Yes	No	Menstrual Difficulties	Yes	No
Hearing Difficulties	Yes	No	Bowel/Bladder concerns	Yes	No
Date of last Dental exam	Month	Year	Date of Last eye exam	Month	Year

If you answered **YES** to any of the above, please give a brief summary: _____
_____

Does your child take any prescription or over the counter medications? Yes No

Please list all medications and indicate why the child is taking it (use separate sheet of paper if needed) and whether they are taken at home, at school or both:

_____

Does your child presently wear glasses or contacts? Yes No Eye Doctor's Name: _____

Please list <u>any other</u> information you feel is important to your child's health: _____

This form is complete and accurate to the best of my knowledge. By signing this form, I give permission to share my child's health information and immunization records with the Wisconsin Immunization Registry (WIR), with my immunization providers and with my child's school district to maintain the most accurate records. Check here if you <u>do not</u> give your permission to share this info. ☐

Parent/Guardian Signature_____ Date_____

OVER for Physician's side of form for Physical Exam

SCHOOLS OF GREEN COUNTY –PHYSICAL FORM

THIS SIDE TO BE COMPLETED BY YOUR CHILD'S HEALTHCARE PROVIDER

Temp:	**Pulse:**	**Resp:**	**BP:**	**Height:**	**Weight:**	**BMI:**	**Weight Management Plan: Yes or No**
Vision	**Right:**	**Left:**	**Referral : Yes or No**		**Other:**		
Hearing	**Right:**	**Left:**	**Referral : Yes or No**		**Acanthosis Nigricans Yes or No**		

PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal
SKIN			**LUNGS**		
HEAD			**HEART**		
EYES			**ABDOMEN**		
EARS			**NEURO, MUSCULAR, BONES**		
NOSE			**SPINE/SCOLIOSIS**		
THROAT/NECK			**GENITALIA, LMP:**		
TEETH Referral needed?			**ENDOCRINE**		

Please describe any abnormal findings:

_____

_____

SIGNIFICANT LAB RESULTS:

_____

IMMUNIZATION HISTORY **Immunizations are up to date? Yes or No Chicken Pox Illness Date:_____**

- □ **Please attach copy of PROVIDER immunization record or WIR copy to this form**

ASSESSMENT: (Synopsis, health promotion, description of abnormal findings)

- □ **Healthy Child ~This child is able to participate in all activities.**
- □ **This child has these restrictions: _____**

PLAN: (Treatment, education, counseling, referrals): _____

Physician Signature: _____ Date of Exam: _____