McFarland Community Schools

STUDENT HEALTH HISTORY

Student Name_____ Date of Birth _____
(Last) (First) (Middle) School_____
Grade_____
Parent/Guardian_____ Home Phone_____

Information obtained from this questionnaire will be kept on file in the health office and used to gain awareness of your child's health need. Emergency or special medical concerns must be clearly communicated to school staff in order to provide safe and effective health care services.

1. Does your child have any of the following conditions? If yes, please explain.

Allergies: (Food, Insect, Meds)	Yes__No___	_____
Asthma: (Inhaler?)	Yes__No___	_____
Attention Deficit Disorder:	Yes__No___	Medication/Dose_____
Bladder or Bowel Problem:	Yes__No___	_____
Bone, Muscle, Joint Disorder	Yes_No___	_____
Congenital Abnormalities:	Yes__No___	_____
Depression/Mood Disorder:	Yes__No___	Medication?_____
Diabetes:	Yes__No___	Injection or Pump (Circle One)
Ear Infection/Problems:	Yes__No___	_____
Epilepsy:	Yes__No___	Medication:_____
Hearing Impairment:	Yes__No___	_____
Heart Condition:	Yes__No___	_____
Migraines:	Yes__No___	_____
Speech/Language Disorder:	Yes__No___	_____
Vision Impairment:	Yes__No___	_____
Past Surgeries	Yes__No__	_____

2. Will your child need any medication to be taken at school? _____
(If child needs Glucagon, Epi-pen, Inhalers, or Diastat -Please provide medication to school and complete medication administration form (available on District website or at school office.)

3. Describe any other health concerns not listed that school staff should know.

_____

I give permission for this medical information to be shared with school staff involved in my child's care.

Signature of Parent/Guardian_____Date_____
For questions, contact the School District Nurse at 838-4500, ext. 4761

12/15AP

PHYSICIAN EXAMINATION RECORD

STUDENT NAME_____

Height_____ Weight_____

Posture_____

Feet_____

Skin_____

Abdomen_____

Hernia_____ Genitals_____

Heart_____

Blood Pressure_____ Pulse_____

Vision: Right Eye_____ Left Eye_____ Hearing (audiometric)_____

Tonsils and Adenoids_____

Lungs_____

Thyroid_____ Other Glands_____

Reflexes_____

Blood Count_____ Hemoglobin_____

Urinalysis_____

Other Lab Exam if indicated_____

Emotional Status_____

General Condition_____

Classification for Physical Education Activity: Record Roman Numeral as indicated below

Code I.	Unlimited Activity
Code II.	Slightly Modified –Under Observation
Code III.	Definitely Restricted –i.e., cardiac disease, post acute infectious diseases, potential chests, etc.
Code IV.	Individual Physical Education
Code V.	Rest

BOOSTERS GIVEN:_____

Date_____ Signature of Physician_____

Clinic Phone_____ Clinic Location_____ 01/03

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