Ilanka Community Health Center

Physical Examination for School Entry

Child's Full Name _____ Gender _____ Birth Date _____

Name of School _____ Date of Examination _____

HEALTH HISTORY: To be completed by the Parent or Guardian prior to the exam.

Does the child have any present illness? YES NO

Past History: Mark X (enter age if yes)

	YES	NO	AGE
Asthma			
Diabetes			
Epilepsy			
Fainting Spells			
Heart Disorder			
Meningitis			
Scoliosis in Family			
Skin Problems			
TB in Family			
Tuberculosis			
Urinary Disorder			

Other illnesses, please describe: _____

Allergies: _____

Birth Defects: _____

Hospitalizations? Why and when? _____

Serious Injuries? _____

Medications child is taking: _____

Vision: Wears glasses / contacts: YES NO

Other eye problems, describe: _____

Hearing problems? Ear surgery? Describe: _____

Other Problems: circle any that apply

Wets Self Soils Unhappy

Speech Discipline Problem Hyperactive

PARENTS COMMENTS: _____

Parent / Guardian Signature _____

Home Address _____

Home / Contact phone _____

PHYSICAL EXAMINATION: To be completed by licensed physician, advance nurse practitioner or physician assistant

Height: _____ inches _____ % Weight _____ lbs _____ %

Vision: R _____ L _____ Both _____ Blood Pressure _____ /_____

Pulse: _____ Respirations: _____ Temperature: _____ °F

☐ Physical Activity Counselling given ☐ Nutrition / Diet Counselling given

	Normal	Abnormal		Normal	Abnormal
Eyes			Abdomen		
Ears			Genitalia		
Nose			Posture		
Throat			Joints		
Teeth			Skin		
Neck			Neurological		
Lungs			Behavioral		
Heart			Emotional		

Describe Findings: _____

IMMUNIZATION STATUS: indicate dates given:

	1	2	3	4	5
DTaP					
Polio					
MMR					
Hepatitis A					
Hepatitis B					
Varicella					
PCV					

TB skin testing will be conducted in the mandated school screening within 90 days of school entry, please defer TB testing.

Is the student able to participate in Physical Education? YES NO

_____

Signature of Examiner Date

_____

Printed Name and Title

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