STUDENT HEALTH INFORMATION
(To be completed by parent/guardian)

Appleton Area School District
Health Services
P.O. Box 2019 - Appleton, WI 54912-2019 - 920-997-1399, ext. 2106 - FAX: 920-832-5764

A physical examination is recommended for students as they enroll for the first time. ***Return Health Information sheet (pages 1 and 2) to the School Nurse.***

*Date*___________________

*Child's Name*_______________________________________ *Birthdate*__________ *Age/Grade*__________

School _______________________________ *Parent's Name*___________________________________

*Family Physician*_____________________________________ *Date of last visit/physical exam*____________

HEALTH HISTORY

1. Does your child have any health conditions, allergies, or food intolerance? Yes_________ No_________
If so, please explain:

2. Is your child taking a daily medication? Yes_________ No_________
If so, please list medication(s) and reason(s):

3. Has your child experienced any serious illnesses, accidents, injuries, or surgeries? Yes_________ No_________
If so, when and please explain:

4. Do you have any concerns about your child's behavior? Yes_________ No_________
If so, please comment:

5. DEVELOPMENTAL HISTORY

a. Was your child considered to be in good health at birth? Yes_________ No_________
If not, please comment:

b. Do you have any concerns about your child's development? Yes_________ No_________
If so, please comment:

c. Do you have any concern about your child's growth, height or weight? Yes_________ No_________
If so, please explain:

6. HEALTH CONDITIONS (Please check diagnosed conditions)

ADHD	_________	Asthma	_________	Concussion/Head Injury	_________
Diabetes	_________	Frequent Ear Infections	_________	Ear Tubes	_________
Genital	_________	Frequent Headaches	_________	Heart Disease	_________
Kidney/Bladder	_________	Mental Health	_________	Muscle Problems	_________
Frequent Pneumonia	_________	Seizures	_________	Other Condition	_________

Please explain conditions checked above:

(continued on other side)

7. DENTAL HISTORY

Do you have a family dentist? Yes_______ No_______

Dentist:_____________________________________

Has your child ever visited the dentist? Yes_______ No_______

Date:_______________________________________

Comments:

8. VISION HISTORY

Has your child experienced any difficulties with vision? Yes_______ No_______

Has your child ever had a professional vision exam? Yes_______ No_______

Doctor:_____________________________________

Date:_________________ Results:______________________

Does your child show symptoms of eye fatigue, stress or infection such as:

______blinking, ______squinting, ______itching, ______tearing, ______redness, ______pus discharge, _____injury

Does your child hold books close to eyes or sit close to TV? Yes_______ No_______

Does your child hold books far away from eyes? Yes_______ No_______

Does your child close one eye or squint? Yes_______ No_______

9. HEARING HISTORY

Has your child been treated medically or surgically for ear problems or frequent ear infections?

Yes_______ No_______

Was your child treated by an ENT specialist? Yes_______ No_______

Name______________________________________

Hearing test results____

Has your child experienced any difficulties with hearing, such as:______turning TV or radio louder, ______turning head to one side, ______frequently misunderstanding instructions, ______asking that instructions be repeated

10. SPEECH

Do you think your child's speech and language development is appropriate for his/her age?

Yes_______ No_______

Is your child: _______difficult to understand, _______raspy, _______nasal, _______a snorer, _______mouth breather?

11. Is there any information about your child that would be helpful to school personnel in working with your child?

The above information is accurate and complete and may be used by school district personnel for educational purposes of my child.

____ ___________________________

Parent/Guardian Signature Date

Please provide a copy of the student's immunization record.

PHYSICAL EXAMINATION
(To be completed by Physician, Physician Assistant or Nurse Clinician)

A p p l e t o n   A r e a   S c h o o l   D i s t r i c t

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*Student's Name*_________________________________ *DOB:*___________ *School/Grade:*__________
*Weight (without shoes)*__________________________ *Height*_______________________________
*BP (sitting)*_________________________________ *Pulse*________________________________
*Vision (distant) R20/*_________ *L20/*_________ *Hearing* *Rt.*___________ *Lt.*__________

	Normal	**Abnormal**	**Comments**
Skin/Scalp	______	______	
Mouth	______	______	
Teeth	______	______	
Ears, Nose, Throat	______	______	
Neck	______	______	
Heart	______	______	
Lungs	______	______	
Abdomen	______	______	
Genitalia	______	______	
Orthopedic	______	______	
Neurologic	______	______	

Other (from positive history):____

____

Immunizations given at this appointment:____

Additional tests/evaluations recommended:____

Restriction/Handicap/Disability: Yes_______ No_______
If yes, please explain:

RECOMMENDATIONS TO SCHOOL:

Examiner's Signature__________________________________ Phone_______________ Exam Date_______________

Please print full name and address of examining health professional:

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Return Physical Examination form to the School Nurse.