



School Entrance Health Questionnaire and Physical Examination

HEALTH QUESTIONNAIRE TO BE COMPLETED BY PARENT/GUARDIAN:

Child's Name _____ Date of Birth: _____ Grade: _____

Health History: Please check YES or NO for the following. If YES, give dates.

	No	Yes	If yes, Date		No	Yes	If Yes, Date
Chicken Pox				Meningitis			
Regular Measles				Tubes in Ears			
German Measles				Strep Throat			
Mumps				Heart Problems			
Whooping Cough				Scoliosis			
Diphtheria				Diabetes			
Rheumatic Fever				Epilepsy			
Scarlet Fever				Surgery			
Tuberculosis				Fracture			
Polio				Wears Glasses			
Asthma				Hearing Problem			

Allergies: Yes _____ No _____

Medicines: _____ Foods: _____

Other: _____

Parent Signature: _____ Date: _____

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN:

Child's Name: _____ Date of physical: _____

Child's Height: _____ Weight: _____

Vision: R _____ L _____ Corrected R _____ L _____

Ears	
Nose	
Pharynx	
Tonsils	
Glands	
Teeth	
Heart	
Lungs	
Hernia	
Skin	
Allergies	
Asthma	
Neurological	
Orthopedic	
Scoliosis	

Last TB Test date: _____ Results: _____

1. Pertinent Health Information (include surgeries, hospitalizations, fractures, etc.)

2. Does child receive daily medication? Yes _____ No _____

If Yes, what medication(s): _____

3. Activity limitations: _____

4. Is the child free of communicable disease? Yes _____ No _____ If No, _____

Please state immunizations given at time of examination: _____

PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD.

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____