School Entrance Health Questionnaire

Please complete and return with the Registration Form.

TO BE COMPLETED BY A PARENT/GUARDIAN

CHILD'S NAME   DATE OF BIRTH   GRADE

HEALTH HISTORY

Check **Yes** or **No** for the following. If **Yes**, please provide dates.

	No	Yes	If Yes, Date
Asthma			
Diabetes			
Epilepsy			
Hearing Problem			
Heart Problem			
Meningitis			
Surgery			
Tubes in Ears			
Wears Glasses			

Allergies: YES NO

Medicines: ______________________

Foods: ______________________

Other: ______________________

PARENT NAME
PLEASE PRINT OR TYPE

PARENT SIGNATURE   DATE
PLEASE PRINT AND SIGN WITH INK

Physical Examination to be Completed by Physician

Return to LCA's main office before the child's first day of school.

CHILD'S NAME ______________________ DATE OF PHYSICAL ______________________

CHILD'S HEIGHT ______________________ CHILD'S WEIGHT ______________________

VISION R __________ L __________ CORRECTED R __________ L __________

LAST TB TEST DATE ______________________ RESULT ______________________

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

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

____

____

Does the child receive daily medication? ☐ YES ☐ NO

If yes, what medication(s)?: ______________________

Activity Limitations:

____

____

Is the child free of communicable disease? ☐ YES ☐ NO *If no:* ______________________

Please state immunizations given at the time of this examination: ______________________

Please attach a copy of the child's immunization record.

PHYSICIAN'S NAME ______________________ PHONE ______________________

PHYSICIAN'S SIGNATURE ______________________ DATE ______________________