ANCHORAGE SCHOOL DISTRICT

PHYSICAL EXAMINATION FOR SCHOOL ENTRY

Name _____ Birth date _____ School _____

HISTORY: ***To be completed by parent prior to exam.***

Does child have any illness now? No _____ Yes_____

If yes, describe: _____

Please (x) any of the following conditions your child has:

____ Diagnosed **ADD or ADHD** – Since when? _____

List medication taken _____

Will medication be needed in school? (Circle) No / Yes

When?_____

A long-term medication form must be completed by your physician if your child needs medication at school.

_____**Allergy** (food, pollen, pets) List:_____

_____What Happens?_____

____ **Bee Sting Allergy –** What happens? _____

_____

EpiPen needed? (Circle) No / Yes *Parent provides EpiPen for school*

____ **Asthma** – Is an inhaler used? (Circle) No / Yes

How often? _____

List all medications taken for asthma _____

_____

Name of asthma doctor _____Last seen for asthma_____

____ **Diabetes –** When was it diagnosed? _____

Name of diabetes doctor _____

____ **Seizures** – What type? _____

Last seizure (date) _____ Seizure Doctor _____

Medication taken for seizures?_____

____ **Hospitalizations** – Date of hospitalization_____

For what? _____

____ **Episode - loss of consciousness?** (Circle) No / Yes

How/When? _____

____ **Joint pain or bone fracture?** (Circle) No / Yes Left / Right

What joint or bone & when? _____

_____

____ **Emotional Concerns** – List _____

_____

____ **Positive TB test** of 10 mm or more. When?_____

BCG? (Circle) No / Yes When?_____

VISION

____ No eye problem. Eye check-up? (Circle) No / Yes When_____

____ Needs glasses _____ all the time _____ for reading

____ had eye surgery – when_____ why_____

HEARING CONCERNS

_____No _____Yes _____ Sometimes

____ frequent ear infections _____ now _____ as an infant/toddler

____ has ear tubes ____ had tubes ____# of times had tubes

____ has a problem with hard wax ____ wears hearing aid

____ **My child is healthy and has no special health concerns.**

Any other health concerns? _____

_____

X _____

Parent / Guardian Signature

_____

Home address

_____ _____

Home phone Emergency phone

Student ID# _____VAX Entered _____

ASD Form 318 (Rev. 5/2001)

PHYSICAL EXAMINATION: To be completed by Licensed Physician, Advanced Nurse Practitioner or Physician's Assistant.

Height _____ in. Weight ____lbs. Sex: M __F__

Vision R ____ L ___Both ____ Blood Pressure _____

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

Describe findings and health conditions that may require treatment at school: _____

_____

_____

IMMUNIZATION DATES

	1	2	3	4	5
DTP/DT					
Polio					
Hib					
MMR					
Hep A					
Hep B					
Varicella					

The PPD skin test given six months prior to school entry is acceptable.

TB skin test by Mantoux (PPD). Must be read by medical professional in 48 – 72 hours. May defer to school TB screening program, if requested by parent.

Date given: _____ Check: ____Negative _____ mm induration

Date read: _____ ____Positive _____ mm induration

Hx note for positive reactor of 10 mm or more:_____

_____

_____

_____

Date of exam

X _____

Signature of Physician, Nurse Practitioner or Physician's Assistant

_____

Printed name and title

_____

Address

_____ _____

Office phone Fax number