SCHOOLS OF GREEN COUNTY –PHYSICAL FORM

THIS SIDE TO BE COMPLETED BY YOUR CHILD'S HEALTHCARE PROVIDER

Temp:	Pulse:	Resp:	BP:	Height:	Weight:	BMI:	Weight Management Plan: Yes or No ☐ ☐
Vision	Right:	Left:	Referral : Yes or No ☐ ☐		Other:		
Hearing	Right:	Left:	Referral : Yes or No ☐ ☐		Acanthosis Nigricans Yes or No ☐ ☐		

PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal
SKIN			LUNGS		
HEAD			HEART		
EYES			ABDOMEN		
EARS			NEURO, MUSCULAR, BONES		
NOSE			SPINE/SCOLIOSIS		
THROAT/NECK			GENITALIA, LMP:		
TEETH Referral needed?			ENDOCRINE		

Please describe any abnormal findings:

_____

_____

SIGNIFICANT LAB RESULTS:

_____

IMMUNIZATION HISTORY **Immunizations are up to date? Yes or No ☐ ☐ Chicken Pox Illness Date:_____**

- ☐ **Please attach copy of PROVIDER immunization record or WIR copy to this form**

ASSESSMENT: (Synopsis, health promotion, description of abnormal findings)

- ☐ **Healthy Child ~This child is able to participate in all activities.**
- ☐ **This child has these restrictions: _____**

PLAN: (Treatment, education, counseling, referrals): _____

Physician Signature: _____ Date of Exam: _____

☐ I recognize that this digital signature takes place of a handwritten signature, pursuant to Wis Stats 137.15, 137.16, & 137.7.

PARENT/GUARDIAN *to complete this page of the form* Grade/Teacher

(Please circle School District) **Monroe** ☐ **Juda** ☐ **Brodhead** ☐ **Albany** ☐ **Monticello** ☐ **New Glarus** ☐

***Please complete the following health history as accurately as possible as you are waiting for your child's appointment. This information will assist both the physician and the school nurse to meet your child's needs at school.**

STUDENT: _____ **DATE OF BIRTH:** _____

PARENT/GUARDIAN: _____ **PHYSICIAN:** _____

FAMILY MEDICAL HISTORY: Please circle yes or no for those diseases that apply to immediate family, which includes the child's siblings, parents, grandparents, aunts, uncles.

Cancer	Yes ☐	No ☐	Sudden Death	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	High Cholesterol	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Elevated Blood Pressure	Yes ☐	No ☐
Depression/Mental Illness	Yes ☐	No ☐	Substance/Drug Abuse	Yes ☐	No ☐

STUDENT HEALTH HISTORY *Please circle yes or no if your child does have or has suffered from any of the following:

Diabetes	Yes ☐	No ☐	Seizures	Yes ☐	No ☐
Asthma (Triggers?)	Yes ☐	No ☐	Neurological	Yes ☐	No ☐
Allergies (food, medications, environment)	Yes ☐	No ☐	Heart Conditions	Yes ☐	No ☐
Hospitalizations/Surgeries	Yes ☐	No ☐	Injuries/Burns/Fractures	Yes ☐	No ☐
Genetic/Congenital	Yes ☐	No ☐	Menstrual Difficulties	Yes ☐	No ☐
Hearing Difficulties	Yes ☐	No ☐	Bowel/Bladder concerns	Yes ☐	No ☐
Date of last Dental exam	Month	Year	Date of Last eye exam	Month	Year

If you answered **YES** to any of the above, please give a brief summary: _____

_____

Does your child take any prescription or over the counter medications? ☐ Yes No ☐

Please list all medications and indicate why the child is taking it (use separate sheet of paper if needed) and whether they are taken at home, at school or both:

_____

Does your child presently wear glasses or contacts? Yes ☐ No ☐ Eye Doctor's Name: _____

Please list <u>any other</u> information you feel is important to your child's health: _____

This form is complete and accurate to the best of my knowledge. By signing this form, I give permission to share my child's health information and immunization records with the Wisconsin Immunization Registry (WIR), with my immunization providers and with my child's school district to maintain the most accurate records. Check here if you <u>do not</u> give your permission to share this info. ☐

Parent/Guardian Signature _____ **Date** _____

☐ I recognize that this digital signature takes place of a handwritten signature, pursuant to Wis Stats 137.15, 137.16, & 137.7.

Submit Completed Form to Albany Schools