

HEALTH RECORD AND PHYSICAL EXAMINATION

NAME OF APPLICANT: _____ AGE: _____

ADDRESS: _____

BIRTH DATE: _____

MEDICAL HISTORY

Illnesses – check and give date:

_____ Rubella: _____ Mumps: _____
_____ Rubeola: _____ Chickenpox: _____
_____ Whooping cough: _____ Polio: _____

ALLERGIES - EXTREMELY IMPORTANT: Give history of **all** allergies, including **drug or food allergies**, and describe the reaction

Asthma - Include treatment, name of medications and frequency, frequency of attacks, number of ER room visits in the last year:

Injuries and Fractures – Provide dates and sites:

Operations – Provide dates and types: _____

Female – Provide menstrual history: _____

Has applicant ever been evaluated or treated by a mental health care professional? If yes, give a brief description of condition: _____

Name of mental health care professional: _____
Address: _____ Phone: _____

Has applicant ever been evaluated or treated for substance abuse issues? If yes, give a brief description of treatment: _____

ARIZONA LAW REQUIRES THAT ALL IMMUNIZATIONS BE VERIFABLY DOCUMENTED BY PHYSICIAN OR CLINIC WITH DATES

IMMUNIZATION HISTORY: Enter Month/Day/Year

(Please read the attached immunization law and make sure your child has all the required doses)

DTP _____
TD _____ HEP A _____
Polio _____
HIB _____
HEP B _____
MMR _____
Chicken Pox (Varicella) _____
OTHER _____

If there are personal or medical reasons that your child has not received the required immunizations, please contact the school nurse for an Immunization Exemption form.

PHYSICAL EXAMINATION

Pulse _____ Resp. _____ B/P _____ Ht. _____ Wt. _____

Findings – State and explain any defects or abnormalities:

Head _____
Eyes _____
Ears/Hearing _____
Nose _____
Mouth _____
Neck _____
Chest _____
Heart _____
Lungs _____
Abdomen _____
Extremities _____
Skin _____
Reflexes-neurological _____

Dental Exam most recent appt. was: _____
Orthodontia in progress? _____

VISUAL EXAMINATION

R. Eye _____
L. Eye _____
Glasses: YES ___ NO ___
Contacts: YES ___ NO ___

LABORATORY (Give dates and findings)

Urine _____
CBC (at Physician's Discretion) _____

REQUIRED FOR ADMISSION – TUBERCULIN TEST

Date: _____ Result: _____
(Any applicant with a positive tuberculin reading must have a chest X-ray)

Chest X-Ray Date: _____ Result: _____

REQUIRED FOR ADMISSION – HEARING & VISION SCREENING AGE 16 AND UNDER

Attach hearing & vision screening results to Physical

Is applicant now under any medical treatment? YES ___ NO ___
If yes, please explain:

Every student is required to take a sport. Should any limitations or restrictions be placed upon applicant's activities?

Does applicant require any therapeutic measures or special care? _____
If yes, explain:

Does applicant take any medicine regularly or occasionally?

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Name of Examining Doctor: _____

(Please Print)

Address: _____

Signature of Examining Doctor: _____

Date of Exam: _____