Mineral Point School District
School Registration Health Exam

Last First Middle	Birth Date	Gender	Grade Level

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES(Food, drug, insect, other)			Medication (List all prescribed or taken on a regular basis)		
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No		Surgery? (List all) When? What for?	Yes No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain	Yes No		Serious injury or illness?	Yes No	
Diabetes?	Yes No		TB skin test positive (past/present)?	Yes No	
Head injury/Concussion/Passed Out	Yes No		TB disease (past or present)?	Yes No	*If yes, refer to local health department
Seizures? What are they like?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Heart problem/Shortness of breath?	Yes No		Dizziness or chest pain w/exercise?	Yes No	
Heart murmur?	Yes No				
Eye/Vision problems? _____ Glasses Y / N Last exam by eye doctor _____ Other concerns? (crossed eye, squinting)			Information may be shared with appropriate personnel for health and educational purposes Parent/Guardian Signature Date		
Ear/Hearing problems?	Yes No				
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

Height Weight BMI B/P

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other condition, frequents travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. ___No test needed ___ Test performed

Skin Test: Date Read / / Result: __Positive __Negative mm _____

Blood Test: Date Reported / / Result: __Positive __Negative Value_____

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes		Amblyopia Y / N	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular			Nutritional status		
Respiratory		__ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ___ Quick-relief medication (e.g. Short Acting Beta Antagonist) ___ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVISES e.g. assistive or implanted

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
Would you like to discuss this student's health with school or school health personnel, check title: ___Nurse, ___Teacher, ___Counselor, ___Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
___ Yes ___ No If, yes, please describe

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION ___ Yes ___ No ___ Modified INTERSCHOLASTIC SPORTS (for one year) ___ Yes ___ No ___ Limited

Print Name (MD,DO, APN, PA) Signature	Date

Address	Phone