

Health History and Physical Examination Form
Independent School District 196-Rosemount, Apple Valley, Eagan

Student's Name _____ M F Date of Birth _____
Last First Middle Month/Day/Yr

Parent/Guardian Name _____ Home Phone _____

Significant Past Health history or present illness: _____

Parent/Guardian: Please complete this section **Health History** Black Ink Please print

	Yes	No	Remark		Yes	No	Remark
Allergies (Specify)				Speech Difficulty			
Asthma				Emotional Difficulty			
Diabetes				Physical Handicap			
Visual Difficulty				Surgery (Specify/dates)			
Seizures				Other:			

Preschool Screening
 Done in District 196? ___Yes ___No
 IEP ___Yes ___No

Please use this space for any concerns or special needs your child may have at school:
 Would you like to have an appointment with the school nurse ___Yes ___No

Physician: Please complete the sections below:

Height _____ in Weight _____ lb BMI _____ Vision R20/ _____ L20/ _____ Corrected Yes No

	Normal	Abnormal	Remarks		Normal	Abnormal	Remarks
Hearing			Right _____ Left _____	Abdomen			
Skin				Genito-Urinary			
ENT				Neurological			
Dental				Nutrition			
Heart				Speech			
Lungs				Emotional			
Varicella Disease	Yes	No	*Date of disease required Sept. 2010 Mo. _____ Yr. _____	Allergies: Please list:			

Medications and treatments to be administered at school:

Is there a condition that may result in an emergency situation Yes No Please explain: _____

Is there a condition that may limit participation? Yes No

Physician Signature _____ Date of Exam _____

Physician Name (print or type) _____ Clinic _____ Phone _____