Appleton Area School District

HEALTH SERVICES * P.O. Box 2019, Appleton, WI 54911 * 920-997-1399 ext. 2106

NEW STUDENT HEALTH HISTORY FORM

A physical examination is recommended for students as they enroll for the first time.
Please return to school office upon completion.

Child's Name_____ Birthdate_____ Age/Grade _____

School _____ Parent's Name_____

Family Physician/Clinic _____ Date of last visit/physical exam _____

HEALTH AND DEVELOPMENTAL HISTORY

1. Was your child considered to be in good health at birth? Yes _____ No _____
   If not, please comment:

2. Do you have any concerns about your child's development? Yes _____ No _____
   If so, please comment:

3. Do you have any concern about your child's growth, height or weight? Yes _____ No _____
   If so, please explain:

4. Do you have any concerns about your child's behavior? Yes _____ No _____
   If so, please comment:

5. Is your child taking a daily medication? Yes _____ No _____
   If so, please list medication(s) and reason(s):

6. Has your child experienced any serious illnesses, accidents, injuries, or surgeries? Yes _____ No _____
   If so, when and please explain:

DENTAL HISTORY

Do you have a family dentist? Yes_____ No _____ Dentist:_____
Has your child ever visited the dentist? Yes_____ No _____ Date:_____
Comments:

VISION HISTORY

Has your child experienced any difficulties with vision? Yes_____ No_____
Has your child ever had a professional vision exam? Yes_____ No_____
Doctor:_____
Date:_____ Results:_____

Does your child show symptoms of eye fatigue, stress or infection such as (check all that apply):
☐ blinking ☐ squinting ☐ itching ☐ tearing ☐ redness ☐ pus discharge ☐ injury

Does your child hold books close to eyes or sit close to TV? Yes_____ No_____
Does your child hold books far away from eyes? Yes_____ No_____
Does your child close one eye or squint? Yes_____ No_____

HEARING HISTORY

Has your child been treated medically or surgically for ear problems or frequent ear infections? Yes_____ No_____
Was your child treated by an ENT specialist? Yes_____ No_____ ENT Specialist: _____
Hearing test results (if any) _____
Has your child had ear tubes placed? Yes_____ No_____ If so, which ear? Right _____ Left _____ Both _____

Has your child experienced any difficulties with hearing such as (check all that apply):
☐ turning TV or music louder ☐ turning head to one side ☐ frequently misunderstanding instructions
☐ asking that instructions be repeated

SPEECH HISTORY

Do you think your child's speech and language development is appropriate for his/her age? Yes_____ No_____
Is your child (check all that apply): ☐ difficult to understand ☐ raspy ☐ a snorer ☐ a mouth breather?

HEALTH CONDITIONS

_____ NO, my child does not have any **diagnosed** health concerns/conditions. (please sign below)

_____ YES, my child has **diagnosed** health concerns/conditions. (please continue below)

YES	CONDITION
	ADD/ADHD
	ASTHMA
	ALLERGIES (Food, Insect, Medications, Environmental) *If yes, please list:*
	BEHAVIORAL/ MENTAL HEALTH (Depression, Anxiety, ODD, Bipolar, Mood disorder) *If yes, please list:*
	DIABETES TYPE 1 OR 2 *Please specify:*
	BLEEDING DISORDER *Please specify:*
	HEADACHES/MIGRAINES *(Please circle one)*

YES	CONDITION
	HEARING/VISION IMPAIRMENT *(Please circle one)*
	HEART CONDITION *Please specify:*
	JOINT PROBLEMS/ARTHRITIS/MUSCULOSKELETAL *Please specify:*
	KIDNEY/BLADDER/BOWEL *Please specify:*
	LOWERED IMMUNITY (Cancer, Transplant, etc.) *Please specify:*
	SEIZURES *Please explain:*
	OTHER *Please specify:*

Is there any other information about your child that would be helpful to school personnel in working with your child? Yes___ No ___
If so, please comment:

The above information is accurate and complete and may be used by school district personnel for educational purposes of my child.

_____ _____
Parent/Guardian Signature Date

For the safety of our students, this information will be placed in the Infinite Campus Health Conditions for staff notification and will be filed in the Student Health File. PLEASE REMEMBER TO PROVIDE A COPY OF STUDENT'S IMMUNIZATION RECORDS.

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PHYSICAL EXAMINATION FORM

(To be completed by Physician, Physician Assistant or Nurse Clinician)

Student's Name _____ DOB _____ School/Grade _____

Weight _____ lbs.
BP _____/_____
Distance Visual Acuity: R 20/_____ L 20/_____

Height _____ inches
Pulse_____
Hearing: R_____ L_____

	NORMAL	ABNORMAL	COMMENTS
Skin/Scalp			
Mouth			
Teeth			
Ears, Nose, Throat			
Neck			
Heart			
Lungs			
Abdomen			
Orthopedic			
Neurologic			
Other			

Are there any restrictions for this student at school? Yes_____ No_____
If yes, please explain:

Were there any immunizations given at this appointment? Yes_____ No_____
If yes, please list:

Are there any additional tests or evaluations recommended for this student? Yes_____ No_____
If yes, please list and/or explain:

Are there any specific recommendations for this student at school? Yes_____ No_____
If yes, please list and/or explain:

Examining Health Professional Contact Information:
Name: _____ Phone: _____ Fax: _____

Clinic: _____ Address: _____

Examiner's Signature _____ Exam Date_____

PLEASE RETURN PHYSICAL EXAMINATION FORM TO SCHOOL OFFICE UPON COMPLETION

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