

ANCHORAGE SCHOOL DISTRICT
PHYSICAL EXAMINATION FOR SCHOOL ENTRY

Name _____ Birthdate _____ School _____

HISTORY: To be completed by parent prior to exam.

Does child have any illness now? No _____ Yes _____
 If yes, describe: _____

Please (x) any of the following conditions your child has:

_____ Diagnosed **ADD or ADHD** – Since when? _____

List medication taken _____

Will medication be needed in school? (Circle) No / Yes
 When? _____

A long-term medication form must be completed by your physician if your child need medication at school.

_____ **Allergy** – (food, pollen, pets) List: _____

What Happens? _____

_____ **Bee Sting Allergy** – What happens? _____

EpiPen needed? (Circle) No / Yes **Parent provides EpiPen**

_____ **Asthma** – Is an inhaler used? (Circle) No / Yes

How often? _____

List all medications taken for asthma _____

Name of asthma doctor _____

Last time seen for asthma _____

_____ **Diabetes** – When was it diagnosed? _____

Name of diabetes doctor _____

_____ **Seizures** – What type? _____

Last seizure (date) _____ Seizure Doctor _____

Medication taken for seizures? _____

_____ **Hospitalizations** – Date of hospitalization _____

For what? _____

_____ **Episode - loss of consciousness?** (Circle) No / Yes

When? _____

_____ **Joint pain or bone fracture?** (Circle) No / Yes, Left / Rt

What joint or bone & when? _____

_____ **Emotional Concerns** – List _____

_____ **Positive TB test** of 10 mm or more. When? _____

BCG? (Circle) No / Yes When? _____

_____ **My child is healthy and has no special health concerns.**

VISION

_____ No eye problem. Eye check-up? (Circle) No / Yes

_____ Needs glasses _____ all the time _____ for reading

_____ had eye surgery – when _____ why _____

HEARING CONCERNS

_____ No _____ Yes _____ Sometimes

_____ frequent ear infections _____ as a baby _____ still

_____ has ear tubes _____ had tubes _____ # of times had tubes

_____ has a problem with hard wax _____ wears hearing aid

Any other health concerns? _____

X

Parent / Guardian Signature _____

Home address _____

Home phone _____ Emergency phone _____

Student ID# _____ VAX Entered _____

PHYSICAL EXAMINATION : To be completed by Licensed physician, Adv. Nurse Practitioner or Physician's Assistant.

Height _____ in. Weight _____ lbs. Sex: M ___ F ___

Vision R ___ L ___ Both ___ Blood Pressure _____

	Normal	Abnormal		Normal	Abnormal
Eyes			Abdomen		
Ears			Genitalia		
Nose			Posture		
Throat			Joints		
Teeth			Skin		
Neck			Neurological		
Lungs			Behavioral		
Heart			Emotional		

Describe findings and health conditions which may require treatment at school: _____

IMMUNIZATION DATES

	1	2	3	4	5
DTP/DT					
Polio					
MMR					
Hep A					
Hep B					
Varicella					

The PPD skin test given six months prior to school entry is acceptable.

TB skin test by Mantoux (PPD). Must be read by medical professional in 48 – 72 hours. May defer to school TB screening program, if requested by parent.

Date given: _____ Check: ___ Negative _____
 mm induration

Date read: _____ ___ Positive _____
 mm induration

Hx note of positive reactor of 10 mm or more: _____

_____ Date of exam

Signature of Physician, Nurse Practitioner or Physician's Asst. _____

Printed name and title _____

Address _____

Office phone _____ Fax number _____

ASD Form 318 (Rev. 6/2000)