PHYSICAL EXAM FOR SCHOOL ENTRY

ANCHORAGE SCHOOL DISTRICT

Name _____ **Date of Birth** _____ **School** _____ **Grade** _____

Home address _____ **Home phone** _____ **Emergency Phone** _____

School Entry Physical must be done up to 12 months before the first day of Kindergarten or school start for other grades.

Part I- HISTORY: To be completed and signed by child's parent/guardian.

To Parent/Guardian: Please check answers to questions 1 through 21 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any current illness?

2. Yes ☐ No ☐ Allergy ((food, drug, latex, airborne, bee sting, other)

3. Yes ☐ No ☐ Asthma or breathing problems

4. Yes ☐ No ☐ Attention-Deficit/Hyperactivity Disorder

5. Yes ☐ No ☐ Bladder/Bowel problems

6. Yes ☐ No ☐ Dental problems

7. Yes ☐ No ☐ Developmental problems

8. Yes ☐ No ☐ Diabetes

9. Yes ☐ No ☐ Head or spinal injury

10. Yes ☐ No ☐ Hearing problem (ear tubes, hearing aids)

11. Yes ☐ No ☐ Heart problems

12. Yes ☐ No ☐ Hospitalizations, operation, or major illness

13. Yes ☐ No ☐ Loss of consciousness

14. Yes ☐ No ☐ Medications

16. Yes ☐ No ☐ Muscle problems

17. Yes ☐ No ☐ Seizure

18. Yes ☐ No ☐ Speech problems

19. Yes ☐ No ☐ TB test positive

20. Yes ☐ No ☐ Vision problems (glasses, contacts)

21. Yes ☐ No ☐ My child is healthy and has no health concerns

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly or occasionally: _____

_____

***A Long-Term Medication form must be completed by your healthcare provider if your child needs medication at school.**
***Parent must provide emergency medications such as Epi-pen, inhaler, glucagon, and diastat if needed in school,**
Immunization record and TB test if done must be provided at school.

X_____
Parent / Guardian Signature

_____

Part II- PHYSICAL EXAMINATION: To be completed by Licensed Physician (MD or DO), Advanced Nurse Practitioner or Physician's Assistant only.

SCREENING RESULTS: Male ☐ Female ☐
Height: _____in. Weight:_____lbs. BMI%: _____
B/P: _____
Vision – w/o Glasses: Right 20/_____Left 20/_____Both 20/_____
Vision - With Glasses: Right 20/_____Left 20/_____Both 20/_____

HEARING – Right: Passed ☐ Failed ☐ Referred ☐

HEARING – Left: Passed ☐ Failed ☐ Referred ☐

	NORMAL	ABNORMAL	TREATED	REFERRED TO
Eyes				
Ears				
Nose				
Throat				
Teeth				
Neck				
Lungs				
Heart				
Abdomen				
Genitalia				
Posture				
Joints				
Skin				
Neurological				
Behavioral				
Emotional				

PPD SKIN TEST: Date given_____Date read_____Result_____mm

This child has the following problems that may impact school success

☐Vision ☐ Hearing ☐ Speech/Language ☐ Physical

☐Social/Behavioral ☐Cognitive Specify: _____

☐This child has a health condition that may require emergency action at school, e.g. seizures, allergies, asthma. Specify _____

☐This child may participate fully in school activities including physical education.

☐This child may participate in school activities including physical education with the following restriction/adaptation. Specify:

_____

Healthcare Provider Signature & Title: ***Date***

Printed Name or stamp:

The Children's Clinic
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