PHYSICAL EXAM FOR SCHOOL ENTRY

Anchorage Waldorf School

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				

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:

12/2016