Breck School Health Center
Student History and Physical Examination Form

Parent or Guardian: Please complete this section prior to seeing physician.

Last name _____ First name _____ Gender: M F Date of birth _____

Parent/Guardian _____ Address _____ City/State/ZIP _____

Parent/Guardian home phone _____ Mobile phone _____ Email address _____

Grade _____ Age _____ Emergency contact (name and phone) _____

Past History — Indicate if your child has ever had:

- ☐ Asthma
- ☐ Chickenpox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ German measles
- ☐ Heart disease
- ☐ High temperature
- ☐ Mumps
- ☐ Red measles
- ☐ Rheumatic fever
- ☐ Scarlet fever

Other (specify):

Serious accident (specify):

Surgery (specify):

Allergies (specify):

Current History — Indicate if your child has recently had problems with:

- ☐ Abdominal pain
- ☐ Allergies
- ☐ Asthma
- ☐ Bladder problems
- ☐ Bleeds easily
- ☐ Bowel problems
- ☐ Clumsiness
- ☐ Dizziness
- ☐ Ear trouble (3 or more/year)
- ☐ Fainting spells
- ☐ Frequent sore throat
- ☐ Hard of hearing
- ☐ Joint pains
- ☐ Persistent cough
- ☐ Physical handicap
- ☐ Poor vision
- ☐ Shortness of breath
- ☐ Speech difficulty
- ☐ Strep throat (3 or more/year)
- ☐ Thumb sucking
- ☐ Tires easily
- ☐ Trouble sleeping
- ☐ Other (specify): _____

Parent/Guardian signature _____ Date _____

Physician: Please complete this section.

Immunizations — Type of Vaccine	**Dose 1** Month/Day/Year	**Dose 2** Month/Day/Year	**Dose 3** Month/Day/Year	**Dose 4** Month/Day/Year	**Dose 5** Month/Day/Year
Diphtheria, Tetanus and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) (formulation for less than 7 years old)					
Tetanus and Diphtheria (Td, Tdap) (formulation for 7 years old and older)					
Polio (IPV, OPV)					
Measles, Mumps and Rubella (MMR)					
Hepatitis B (hep B)					
Varicella (chickenpox)					
Pneumococcal Conjugate (PCV)					
***Haemophilus influenzae* type B** (Hib)					
Meningococcal (MPSV4, MCV4)					
Human Papilomavirus (HPV)					
Hepatitis A (hep A)					
Rotavirus					
Other (specify)					

Examination — indicate Normal (N) or Abnormal (AB). If Abnormal, comment below.

	N/AB
Skin/Lymph	
Eyes	
Ears	
Nose	
Mouth	
Throat	
Neck	
Heart	
Lungs	
Abdomen	
Genito – Urinary	
Orthopedic – Feet	
Orthopedic – Spine	
Neurological	
Speech	
Other (specify)	

Tests — indicate Normal (N) or Abnormal (AB). If Abnormal, please comment below.

Test	**N/AB**	**Test**	**N/AB**
Tuberculin		Urine	
Hemoglobin/Hematocrit		Scoliosis	

Measurements — Give exact value.	
Blood pressure	
Height	
Weight	
BMI	

Vision: R 20/_____ L 20/_____
With glasses? Yes No

Hearing: R _____ L _____
With hearing aid? Yes No

Health Classification for School Programs

- ☐ Is in excellent health and able to participate in all school programs.
- ☐ There is a condition that may limit participation in (circle as many as apply):
  Classroom activities Physical Education Competitive sports
  Reason(s) and recommendation(s): _____
  Is the above classification temporary? Yes No For how long? _____

Is there a condition that may result in an emergency situation? Yes No
If yes, specify: _____

Ongoing therapies and medications — specify type and dose: _____

Problems/Comments (as indicated above)	**Recommendations or plans**

Physician Signature | Physician Name (please print) | Physician Address / Phone | Date of Examination

White copy (School) | Yellow copy (Parent/Guardian)