

Pilgrim Lutheran School

**1731 St. Agnes Drive
Green Bay WI 54304**

Health History and Physical Examination Form

Form #31

Parents: In order for your child to register and attend school, this form must be completed, signed and returned to school.

Please complete this form before taking your child to the doctor.

Child's Name _____ Birthdate ___/___/___ M__F__ Race _____

Address _____ Home Phone _____

Fathers Name _____ Mother's Maiden Name _____

Please answer yes or no after each item

Family history of:

Tuberculosis ___ Cancer ___ Heart Disease ___ Thyroid problem _____

High Blood Pressure ___ Emotional problem _____ Learning problem _____

History of child's illness:

Diabetes ___ Allergies ___ Kidney problem ___ Seizures ___ Asthma _____

Mumps ___ Rheumatic fever ___ Congenital heart disease ___ Ear Infections _____

Chicken pox ___ Strep throat ___ Whooping cough ___ German measles or 3

day measles ___ Scarlet Fever ___ Measles ___ Rubella _____

Infectious Hepatitis ___ Other _____

Does your child have problems with any of the following?

Skin ___ Eating ___ Bowels ___ Urination ___ Muscles or bones ___ Sleeping _____

Heart or lungs ___ If yes, please describe _____

Has your child had any serious injuries? _____ If yes, please describe _____

Is your child allergic to any thing? _____ Please describe _____

Has your child ever been hospitalized? _____ Reason _____

Does your child take any medication regularly? _____ Medication _____

Frequency _____ Reason _____

Does your child wear glasses? _____ Is your child color blind? _____

Does your child have a hearing problem? _____

Has your child ever had a TB skin test? _____ If so, when _____ Results _____

Was your pregnancy with this child: 9 months ___ Longer _____ Shorter _____

Any illness during pregnancy? _____

Any complications at delivery? (mother or baby) _____

For the Physician

This should be a complete physical examination with evaluation of the following:

Eyes, ears, nose, mouth, throat, heart, lungs, nutritional status, and laboratory work if necessary.

Any needed immunizations?

Findings:

Medications: _____

Vision: Right: _____

Left: _____

Other: _____

Recommendations:

- _____ Recheck child
- _____ Further immunization needed
- _____ Refer to specialist
- _____ Special conference with school personnel

Date: _____

Signature of examining Physician