Physical Exam Form

Required for students 8 years old and younger new to Kansas Schools

Name:_____ Birthdate:_____

Family Health History:

Response Codes: M = Maternal P = Paternal S = Sibling NA = Not applicable

	Code	Comment
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions, mental illness, substance abuse, or others? Comment?		
2. Does any family member have a vision defect, hearing loss, or spinal deformity? Comment?		

Child/Adolescent History:

Response Codes: Y = Yes N = No NA = Not applicable

1. Birthweight _____ Were there any pre-natal or delivery problems with the child?		
2. Did this child walk, talk, and develop at the usual time?		
3. Does this child/adolescent:		
a. See a health care provider regularly?		
b. Use any medication, drugs, or alcohol?		
c. Have a history of any hospitalizations, surgeries, or emergency room visits?		
d. Have a history of any childhood diseases/illnesses?		
e. Have a history of other communicable diseases?		
f. Age menarche _____ Have a history of menstrual problems?		
g. Have a history of vision, speech, hearing, or communication problems?		
h. Have a problem with being tired or overactive?		
i. Have any emotional or behavioral problems?		
j. Need any special help in school or day care?		
k. Have sexuality concerns?		

l. Have any chronic illness or disabling problems with:

Headache ____ Convulsions ____ Diabetes _____ Earaches _____ Back/spine/
Cold/sore throat ____ Rheumatic fever ____ Genitalia _____ Oral/dental _____ extremity problem _____
Heart/lung disease ____ Allergies/asthma ____ Digestive _____ Urinary/bowel _____ Other _____

List present concerns of child/parent/guardian:

A copy of the student's shot record is required at enrollment.

BRING THIS COMPLETED PAGE 1 WITH YOU TO THE PHYSICAL EXAM

Name:_____

Physical Examination: To be completed by health care provider approved to perform health assessments.

Height	_____	**Weight**	_____	**Hgb or Hct**	_____
Pulse	_____	**Blood Pressure**	_____	**Lead**	_____
Urinalysis	_____	**Sickle Cell**	_____	**Other**	_____
Tuberculosis	_____	**Head Circumference**	_____	**BMI%**	_____

Code Each Item as Follows: **0 = No significant findings** **1 = Significant findings**	**Code**	**Description of Findings**
General Appearance **Integument** **Head – Neck** **EENT** **Oral – Dental** **Thorax** **Breasts** **Cardiovascular** **Abdomen** **Musculoskeletal** **Genitourinary** **Neurological**		

Screening:

1. **Nutritional Evaluation** (all ages – each screen) (✓ if applicable) Nutrition/WIC Questionnaires available from (913) 296-0092.

☐ Enroll in WIC ☐ Receiving Vitamin Supplement with iron ☐ Without iron ☐ Fluoride Supplement

Food intake review. Results:

milk/milk products (breastfed/type of formula)_____

fruit/vegetables_____

meats, beans, eggs_____

breads, cereals_____

2. Development: Type of screen _____ Results_____

3. Speech: Type of screen _____ Results_____

4. Hearing: Type of screen _____ Results_____ Date of last screen_____

5. Vision: Type of screen _____ Results_____ Date of last screen_____

Significant Assessment Findings:

Recommendations: (include referrals)

Anticipatory Guidance: (circle those discussed)

1. Safety/poisons
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunization
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

This student is cleared for participation in all organized youth sport/activities Yes_____ No_____

Additional information may be attached

_____ _____

Signature of Licensed Physician/Nurse approved to perform health assessments Date