Middleton-Cross Plains Area School District
Physical and Dental Form

TO BE FILLED OUT BY PARENT/GUARDIAN

Child's Name: _____ Birthdate:_____Sex _____
School:_____ Grade:_____

Parent/Guardian:_____
Address:_____
_____
Phone: _____ Home _____

Primary Physician:_____ Date of last visit: _____
Clinic Name: _____
Clinic Address: _____
_____
Phone: _____

Dentist's Name:_____ Date of last visit: _____
Address: _____
_____
Phone: _____

Was dental treatment completed?
Yes _____ No ____ Not needed ____

In an effort to provide a safe, healthy environment for your child at school, we would like to know about your child's health needs.

1. Have there been any major changes in the family situation in the last year, such as a family moving, loss of someone close, or a serious illness of either parent? Yes ____ No ____ If yes, please describe:

2. Has your child had any serious accidents, illnesses, hospitalizations or injuries in the past year? Yes ____ No ____ If yes, please describe:

3. Please describe any health concerns or medical diagnosis your child may have (i.e. asthma, seizure disorder, diabetes, hearing or vision concerns, or <u>any</u> health concern).

4. Does your child take any medications regularly? Yes ____ No ____ If yes, please list.

5. Please give any additional comments/information that you would like to share about your child.

6. Has there been any tuberculosis exposure? Yes ____ (yr _____) No ____. If yes, please describe treatment.

May this information be shared with appropriate school personnel, as determined by the school nurse?
Yes _____ No _____

If your child has a health concern, may this information be included on a health concern list that is distributed to staff and maintained in the school health office? Yes ____ No ____

Signature of Parent of Guardian: _____Date:_____

<u>PLEASE RETURN TO YOUR CHILD'S SCHOOL HEALTH OFFICE</u>

TO BE FILLED OUT BY YOUR PRIMARY PHYSICIAN

Physical Examination

Height _____ Weight _____ Blood Pressure _____ Pulse _____ General appearance _____ General nutrition _____
Vision: Acuity right eye _____ left eye _____
Hearing: Audiogram right ear _____ left ear _____

TEST	NORMAL	ABNORMAL	NOT DONE	COMMENTS
Skin				
Head				
Eyes				
Ears				
Nose				
Mouth				
Throat				
Neck				
Nodes				
Chest				
Lungs				
Heart				
Abdomen				
Genitourinary				
Neuromuscular				
Spine				
Extremities				
Anus				
Sexual Development				

Please describe any significant disabilities, developmental concerns or abnormal findings which would be helpful for the nurse to know about when providing care in the schools.

Please list any immunizations given today:

Is this child on any routine or long term medication? Yes ____ No ____ If yes, please describe:

Physician's Signature: _____ Date: _____Phone: _____

TO BE FILLED OUT BY THE DENTIST

Dental Examination:

__Child is involved in a preventive dental health program. __ All necessary dental work has been completed.
__Treatment is in progress. __ No dental work is necessary.
Dentist's Signature: _____ Date: _____ Phone:_____