ANCHORAGE SCHOOL DISTRICT — PHYSICAL EXAM FOR SCHOOL ENTRY

Name _____ **Date of Birth** _____ **School** _____ **Grade** _____

Home address _____ **Home phone** _____ **Emergency Phone** _____

Physical examinations are no longer required for school entry as of June 30, 2016. To facilitate mandated physical screenings, parent/guardian may provide the school nurse a completed copy of this form if a physical exam was completed within the last year.

Part I- HISTORY: To be completed and signed by child's parent/guardian.

To Parent/Guardian: Please check answers to questions 1 thru 21
(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

Please explain any "Yes" answers from above.

_____

_____

List all medications (prescription or over-the-counter) your child takes regularly or occasionally: _____

_____

If your child will be taking medication or requires treatment or has a plan (asthma, allergy/anaphylaxis, diabetes, seizure), please ask the nurse for required forms.
Emergency medications such as Epi-pen, inhaler, glucagon, and diastat must be provided by parent/guardian 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: _____

Distance Vision: ☐**Sloan** ☐**Lea** ☐**HOTV**
Without Glasses: Right 20/_____**Left 20/**_____**Both 20/**_____
With Glasses: Right 20/_____**Left 20/**_____**Both 20/**_____
Vision Referral ☐Yes ☐No

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 in school activities including physical education with the following restriction/adaptation. Specify:**_____

_____

☐**This child may participate fully in school activities including physical education.**

_____

Healthcare Provider Signature & Title: _____
Date: _____

Printed Name or Stamp: