## History and Physical Report Saul Mirowitz Jewish Community School

The <u>School requires a physical examination</u> at the time a <u>child first enrolls</u> and <u>when entering Kindergarten,  $4^{th}$  and  $7^{th}$  grade</u>. The physical exam must have been done by the child's health care provider and dated on or after August  $1^{st}$  of the previous year to be valid for this school year.

PARENT SECTION  State law requires complete immunizations records. Please attach a record from the child's health care provider. Month, day, and year must be provided for all immunizations, including infant series.							
Child's Name			Date of	Birth			
Address	Phone						
City		_ State _		Zip Code			
Mother's Name	Work	Phone					
Father's Name	NameWork Phone						
Name of Child's Primary Health Car	re Provider:						
Address:	Phone						
City	State		Zip Cod	le			
Health History: Enter the year(s) in	which your child had:						
ASTHMA	MUMPS	_ CHIC	CKENPO	OX			
ANEMIA	MENINGITIS	_ TUB	ERCUL	OSIS			
ALLERGIES	SEIZURES	_ DIA	BETES				
HEART PROBLEMS	HEPATITI	S A	B_	C			
Does your child wear glasses? Yes_	No	Contact	s? Yes	No			
Health Information: Please list any problems, hearing loss, and/or any o							
Does your child have any dietary res							
Is your child taking medication at ho	ome? (Please list):						
Is your child currently under medica	l care for any health conditi	on(s)? (P	lease ex	plain)			

The reverse side of this form is to be completed by the child's health care provider. Once completed, this form and the immunization record are to be mailed or faxed to the School.

Child's Name					
Date of physical exam:			Ht	Wt	
Dute of physical exam.	NORMAL	<b>D</b> /1	ABNORMA		
General Appearance					
Skin/Scalp					
Head, Neck, Thyroid					
Eyes					
Ears				_	
Nose, mouth, throat				_	
Teeth and gums				_	
Lymph					
Musculoskeletal/ortho					
Lungs					
Cardiovascular				_	
Abdomen					
Genitalia					
Neurological					
Visual Acuity:					
Type of test:	Results: OD		With / without glass	es With / without contacts	
Date:			With / without glass		
Hearing:					
Type of test	Date:		Results: R	L	
Please complete this section if 1					
Lead screen (ages 6-72 mos): I		•	_	Results	
Urinalysis: Date I					
PPD: Type of test: Mantoux /			Date read	Results	
Recommendations and remarks (	including allergies,	medically in	dicated dietary restri	ictions, acute or chronic illness	
Should physical activity be restri	cted? No	Yes	If yes, please expl	lain	
	copy of the most	current in	ımunization recor	rd. Thank you.	
<b></b>					
Hoolth Care Provider Signatur				Phone Number	

**Health Care Provider Signature** 

Printed Name

Phone Number