History and Physical Report
Saul Mirowitz Jewish Community School

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

PARENT SECTION

Student's Name: _____ **Age:** _____
(last) (first) (middle)

Date of Birth: _____ **Grade:** _____ **Gender Identity:** _____

Address: _____

City: _____ **State** _____ **Zip Code** _____

Mother's Name: _____ **Preferred Phone Number:** _____

Father's Name: _____ **Preferred Phone Number:** _____

Name of Student's Primary Health Care Provider: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Does your child have any allergies? *(including food, drug and environmental allergens)* **YES / NO**

_____

Is your child currently under care for any medical or mental health condition(s)? **YES / NO**

_____

Is your child taking any medication at home? **YES / NO**
(Specify name of medication(s) and reason for taking).

_____

Health History: *Please indicate if your child has any of the following conditions*

ASTHMA _____ **ANEMIA** _____ **ALLERGIES (***SEASONAL)* _____

SEIZURES _____ **DIABETES** _____ **FREQUENT STREP** _____

Does your child wear glasses? Yes _____ **No** _____ **Contacts? Yes** _____ **No** _____

Health Information: Please list any injuries, operations, serious illness, heart conditions, vision problems, hearing loss, and/or any other health information you feel would be helpful.

_____

_____

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

Parent/Guardian Printed Name	*Parent/Guardian Signature*	*Date*

HEALTH CARE PROVIDER SECTION

Please attach a copy of the most current immunization record

Student's Name: _____ DOB: _____

Date of physical exam: _____ B/P _____ Ht _____ Wt _____

	NORMAL	ABNORMAL FINDINGS
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: _____ Date: _____
Results: OD _____ With / without glasses With / without contacts
OS _____ With / without glasses With / without contacts

Hearing: Type of test _____ Date: _____ Results: R _____ L _____

Please complete this section if results are available for any of the following:

Lead screen (ages 6-72 mos): Date _____ Results _____ Hgb: Date _____ Results _____

Urinalysis: Date _____ Results _____

PPD: Type of test: Mantoux / Tine Date tested _____ Date read _____ Results _____

Recommendations and remarks *(including allergies, medically indicated dietary restrictions, acute or chronic illness)*

_____

_____

Should physical activity be restricted? No_____ Yes_____ *If yes, please explain*_____

_____

_____ _____ _____

Health Care Provider Signature *Printed Name* *Phone Number*