

LOMIRA SCHOOL DISTRICT

HEALTH INFORMATIONS FORM/COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Personal Data ***Please bring your child's shot records with on the first day of school***

Student's Name _____ Current Grade _____

Student's Date of Birth ___/___/___ Male ___ Female ___

Parental Consent: I agree to allow my child's health care provider and School Nurse or designee to discuss information on this form to better understand health needs of my child.

Print Name: _____

Signature: _____ Date: _____

COMPLETED BY HEALTH CARE PROVIDER

No Recommendations, Concerns or Needs Request School Follow Up

Medication:

Child takes medicine at home for specific health conditions: Yes No

List of medication(s): 1. _____ 2. _____
3. _____ 4. _____

Medications that will be supplied by the parent and may be given at school: (Permission slip required.)

Scheduled Med(s): 1. _____ 2. _____ 3. _____

Allergies: Food _____ Insect: _____ Medicine _____
 Other _____

**Is Epi-Pen or Benadryl used for allergies(Additional form required): _____

Pertinent Illness, Risks or Developmental Problem: explain below.

- Diabetes Allergies Seizures Tubes in Ears Bleeding disorder
 Asthma Attention/Learning Genetic Disorder Prematurity (<32 wks) Speech/language
 Skin Hearing Vision Bowels Kidney
 Emotional/Behavioral

Please explain any of the above:

Physician's Findings after exam of eyes, ears, nose, mouth, throat, heart, lungs, nutritional status, laboratory work as indicated, immunization update.

Vision: Right: 20/___ Left: 20/___ Both: 20/___ Weight: _____ lbs Height: _____ ft. _____ in.

Recommendations or suggested follow up:

Signature of examining physician: _____

Date: _____