CLINTON TOWNSHIP SCHOOL DISTRICT
STUDENT HEALTH HISTORY AND PHYSICAL EXAM FORM

Part A: HEALTH HISTORY - Completed by the parent/guardian and reviewed by examining licensed provider
Part B: PHYSICAL EXAMINATION - Completed by examining licensed provider

Student's Name: _____ Sex ____M ____F

Birth Date: _____ Grade: _____ Languages Spoken at home: _____

Parent/Guardian Names: _____

PART A: HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers, including the year:

_____
_____
_____
_____
_____

Operations or Serious Hospitalizations:

_____
_____
_____

Current Medications (Name, Dose, Frequency and Reason used):

_____
_____
_____

Allergies: (Name, reaction to exposure)

Drug: _____
Food: _____
Environmental: _____

Any Other Additional comments or information that you would like to provide:

_____
_____
_____

Student's Name: _____ Date of Physical Exam: _____

PART B: ANNUAL PHYSICAL EXAMINATION
(Completed by examining licensed provider)

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:

	Normal Exam	Abnormal Findings:
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Physical Exam Comments:

_____

_____

_____

_____

Any Limitation of Activity or other Recommendations? ☐ No ☐ Yes (Please define):

_____

_____

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.

2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: _____ Date: _____
Name and Address Stamp: