WAUKEE COMMUNITY SCHOOL DISTRICT
MEDICAL REPORT

Student Name____ Gender M F Birthdate _____________
Parents/GuardianName____
Address____ City_____________________ State__________
School of Attendance_______________________________________ Grade __________

SIGNIFICANT HEALTH HISTORY

Yes	No		Yes	No	
		Asthma			**Hospitalizations** (List Below)
		Seizure Disorder			**Surgeries** (List Below)
		Diabetes			**Allergies**
		Heart Disorder			
		Pleurisy/Pneumonia			
		Rheumatic Fever			
		Scarlet Fever			**Medications**
		Eczema			
		Meningitis			
		Chicken Pox			
		Other (List Below)			

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PHYSICAL EXAMINATION / PHYSICIAN REPORT

X = Normal or Negative			RESULTS
	Appearance	Height **(Required)**	
	Posture	Weight **(Required)**	
	Nutrition	Blood Pressure **(Required)**	
	Development	Hemoglobin	
	Neurological	Urinalysis	
	Speech Defect	Blood Lead Level **(Required)**	________ ug/dL Date Completed_____________
	Hair / Scalp	Hearing Screening **(Required)**	Referral Yes______ No_______
	Nose	Vision Screening **(Required)**	**R** /20 **L** /20 **Both** /20 Referral Yes_______ No ________
	Ears		
	Throat	Chronic Disease	
	Thyroid	Physical Education	Full _______ Limited _______ None ________
	Lymph Nodes	Anatomical Restrictions	
	Heart	**Physician's Comments and Recommendations**	
	Lungs		
	Extremities		
	Abdomen		
	Skin		
	Hernia		
	Back		

Physicians Signature______________________________________ Date of Exam____________

Health History Form (to be completed by parent or guardian)

1. Name of child_________________________ Birth Date_____________

2. Pregnancy, Birth & Development:
   - a. Were there any difficulties during pregnancy? Yes No
     - If yes, explain:_____________________
   - b. Was this child carried for full 9 months? Yes No
   - c. Birth weight ________lb. ________oz.
   - d. Any problems in the hospital during/after birth? Yes No
   - e. Did this child sit alone before 7 mos. of age? Yes No
   - f. Did this child walk alone before 15 mos. of age? Yes No
   - g. Did this child say words by 1&1/2 yrs. of age? Yes No
   - h. Check if the following have occurred with this child:
     - ____sleeping problem ____eating problem
     - ____excessive drooling ____coordination problem

3. Illness and Accidents

   Has this child:

a. Had more than 1 ear infection each year?	Yes	No
b. Had more than 2 throat infections each year?	Yes	No
c. Had a hearing problem?	Yes	No
d. Had a vision problem?	Yes	No
e. Had allergy problems, wheezing or asthma?	Yes	No
f. Had frequent colds, sinus infections, hay fever?	Yes	No
g. Received any routine medications?	Yes	No
h. Had serious reactions to any medicine or injection?	Yes	No
i. Had any problems with bladder or kidneys?	Yes	No
j. Had any problems with bowels or constipation?	Yes	No
k. Ever had convulsions or seizures?	Yes	No
l. Had a weight problem?	Yes	No
m. Had any serious accidents?	Yes	No
n. Had any problems with fainting?	Yes	No
o. Had any problems with headaches?	Yes	No

Please explain any "Yes" answers:

4. Family Health

   Do any other family members have any serious health problems? If yes, please explain:

5. Additional Health Concerns

   Please let us know of any additional health concerns or physical limitations of this child.

Filled out by ______________________________Date___________________________