

# WILDWOOD SCHOOL

## HEALTH SERVICES

### K - 5<sup>th</sup> GRADE PHYSICAL EXAMINATION FORM

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_

#### Health History

(to be completed by the parent)

Has your child had or do they currently have:

a. Any injury, illness, hospitalization or ER visits since their last exam? Y/N

If so, please list: \_\_\_\_\_

b. Any allergies to foods, bee stings, latex, pollen? \_\_\_\_\_

If so, to what? \_\_\_\_\_

Please describe reaction: \_\_\_\_\_

c. Does your child currently take any medication prescribed by a doctor or over the counter medication on a daily basis? Y/N

If so, please list: \_\_\_\_\_

d. Does your child take any medication on an as needed basis? Y/N  
 (i.e. Epipen, Albuterol inhaler, etc.)

Please list: \_\_\_\_\_

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### To be Completed by MD Office

Vaccine Type	Disease MM/DD/YR	1 <sup>st</sup> Dose MM/DD/YR	2 <sup>nd</sup> Dose MM/DD/YR	3 <sup>rd</sup> Dose MM/DD/YR	4 <sup>th</sup> Dose MM/DD/YR	5 <sup>th</sup> Dose MM/DD/YR	Booster MM/DD/YR
DPT/DtaP/TdaP (Indicate type)	/ /						
IPV (indicate if OPV)	/ /						
MMR (indicate if separate vaccine)	/ /					Measles Serology	Titer: Date:
Meningitis	/ /					Mumps Serology	Titer: Date:
Hepatitis B	/ /					Rubella Serology	Titer: Date:
Varicella	/ /					TB Screening (Mantoux)	
HIB (Preschool)	/ /					Tested _____	
Influenza (Preschool)	/ /					Read _____	
Pneumonia (Preschool)	/ /					Result _____	
Other	/ /						
Other	/ /						

PLEASE COMPLETE BOTH SIDES

