

School District of Hartford Jt. #1

675 E Rossman St

Hartford WI 53027

Phone 262-673-8042 Fax 262-673-8045

www.hartfordjt1.k12.wi.us

HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

Parents: A Physical and Vision exam are strongly encouraged prior to Kindergarten but are not required for admission to school.

Please complete this side of the form before taking your child to the doctor.

Child's name _____ DOB _____ M F

Address _____ Phone: _____

Father's Name _____ Mother's maiden name _____

HISTORY OF CHILD'S ILLNESS: PLEASE WRITE YES OR NO AFTER EACH ITEM

Diabetes _____ Allergies _____ Kidney Problems _____ Seizures _____ Asthma _____
Rheumatic Fever _____ Congenital heart disease _____ Ear Infections _____ Rubella (hard
measles) _____ rubella (German measles) _____ Mumps _____ Chicken Pox _____ Whooping
cough _____ Scarlet fever _____ Strep throat _____ Infectious hepatitis (infectious jaundice)
_____ Other _____ Explain: _____

Does your child have problems with any of the following?

Skin _____ Eating _____ Bowels _____ Urination _____ Sleeping _____ Muscle/Bones _____ Heart
_____ Lungs _____ if Yes, please describe _____

Has your child had any serious injuries? If yes, please describe:

Has your child ever been hospitalized? _____ If yes, when _____

Does your child take any medications regularly? _____ Will they be needed at school? _____
Medication _____ Frequency _____ Reason _____

Does your child wear glasses? _____ color blind? _____ Does your child have a hearing
problem? _____

Has your child ever had a TB test? _____ If so, when _____ Results _____

Was your pregnancy with the child pre-term (less than 8 ½ months)? _____ Term (9 months)

Any illness or complications during pregnancy? _____

Any complications at birth? _____

My family physician is _____

Address _____ Phone _____

Continued on Back

FOR THE PHYSICIAN:

This should be a complete physical examination with evaluation of the following:

Eyes, ears, nose mouth, throat, heart lungs, nutritional status, laboratory work as indicated, any needed immunizations.

Findings:

Medications:

Date

Signature of examining Physician

Vision:

Right: 20/ _____

Left: 20/ _____

Recommendations:

- recheck child
- further immunization needed
- refer to specialist
- special conference with school personnel

Date

Signature of examining Physician (if different than above)

Please return form to: School District of Hartford Jt. #1
Pupil Services Dept
675 E Rossman St
Hartford WI 53027