LITTLE ROCK SCHOOL DISTRICT
HEALTH SERVICES

HEALTH HISTORY AND PHYSICAL RECORD

The Arkansas Department of Education requires every student to receive a physical examination at the beginning of his/her school experience. All students transferring from another district are required to have a physical. Please have your child examined and return this form to school. You may contact the school nurse if you have any questions. This form may be returned by fax to your child's school.

This side is to be completed by the parent or guardian before seeing the physician

Student's Name:	Grade	Birth Date	Sex	Race
Mother's Name:	Mother's age at child's birth:		Child's Birth Weight:	
Father's Name:	Physician:		Dentist:	
( ) ARKids 1st or Medicaid or ( ) Private Insurance Number (or any other financial assistance):			Last Visit to Dentist:	
PLEASE LIST ANY CONCERNS YOU HAVE ABOUT THE HEALTH OF YOUR CHILD:				

Has your child had any difficulties concerning the following? (Please circle the appropriate box)

Vision Problems	Yes	No	Diabetes	Yes	No	Snoring/Sleep Problems (Sleep Apnea)	Yes	No
Hearing Problems	Yes	No	Convulsions (Seizures)	Yes	No	Birth Defects	Yes	No
Ear Infections	Yes	No	Tuberculosis	Yes	No	Serious accident or burn	Yes	No
Allergies	Yes	No	Kidney Disease	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Sickle Cell Trait	Yes	No

Other Conditions (Please name):

Give dates if your child has had any of the following illnesses:

Chicken Pox:	Meningitis:

Describe any serious accident, injury, surgery, or illness your child has had:

Does your child's family (father/mother's side) have any of the following conditions? (Please mark appropriate box)

Diabetes before age 50	Yes	No	Heart Disease before age 50	Yes	No	Sickle Cell Anemia	Yes	No
Convulsions (Seizures)	Yes	No	Black out spells	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Mental Retardation	Yes	No	Sinus Problems /Allergies	Yes	No

Other Family Disease(s) (Please Name):

A physician or health care provider must complete this side

Student's Name:	Birthdate:

Attach a copy of immunization record

EXAMINATION Date:	**Codes: S = Satisfactory X = Abnormal C= Corrected**

Height: Inches:			**Weight: Pounds**	**B/P:**
1. Emotional Health			7. Mouth/Teeth	13. Hernia
2. Physical Appearance			8. Throat	14. Genitalia
3. Skin and Scalp			9. Neck	15. Neurologic
4. Eyes/Vision	R	L	10. Heart	16. Extremities
5. Ears/Hearing	R	L	11. Lungs	17. Development
6. Nose			12. Abdomen	18. Nutrition
Lab Work (optional):			Hemoglobin/Hematocrit:	Urinalysis:

Please explain any abnormal finding and/or list any condition which may affect this child's performance at school:

Medication given during school hours must be in the prescription bottle or original container. It will be kept in a specifically designated place in the health room or office and a permission slip must be signed by the parent.

Medication:	**Reason:**
Medication:	**Reason:**

Health classification for school activities (please check one):

( ) This student is able to participate in the regular school program including physical education and athletics.

( ) This student is to be restricted from _____ because of _____

for a length of time of _____.

( ) Parent present and understands.

Physician's Signature _____ Date _____

Telephone _____