

Health History Exam

Fremont Unified School District, 4210 Technology Dr., PO Box 5008, Fremont, CA 94538 (510) 657-2350

Name _____ Birthdate _____ Male ___ Female ___ Grade ___
 School _____ School Address _____

Health History (To be completed by parent)

Current Health Status:

- | | | |
|---|---|--|
| <input type="checkbox"/> Special or poor eating habits | <input type="checkbox"/> Vision – wears glasses | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hearing difficulties, infections | <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Convulsive disorder |
| <input type="checkbox"/> Frequent colds or sore throats | <input type="checkbox"/> Diet or nutritional problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Weight problems | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Pains in extremities or joints | <input type="checkbox"/> Allergies | <input type="checkbox"/> Physical handicap |

Further explanation of above items: _____

Dental condition: _____ Name of Dentist _____

Medication: Please list name and dosage of any medication your child is taking. _____

Currently under a physicians care? ___ Yes ___ No For what condition? _____

Parent's Authorization:

I hereby give my consent to the school named above to receive from or send to Dr. _____ any information concerning my child.

Parent's signature: _____ Date: _____

Physical Examination (To be completed by doctor.)

Significant findings: Please consider dental condition, EENT, heart, lungs, abdomen, neurologic deficit, behavior and emotional adjustment. _____

Significant diagnostic evaluation, observation, recommendations: (Special Education services are available to children with handicapping conditions or special needs.) _____

Recommendations for physical activity: _____ Unrestricted ___ Restricted ___ Athletic participation

Medication: Name and dosage. _____

Immunizations: Month, Day, and Year are required.

	1 st	2 nd	3 rd	4 th	5 th
Polio					
DTaP/DT/Td					
Hib					
Hepatitis B					
MMR					
Varicella					

Hearing: Right _____ Left _____ Vision: Right _____ Left _____

Laboratory test results: hematocrit _____ hemoglobin _____ urinalysis _____ blood pressure ____ / ____

Medical care: Is this child currently under your care? _____ How long? _____

Other medical specialists involved: _____

South East Bay Pediatrics: 2191 Mowry Ave., Ste. 600C, Fremont CA 94538 (510) 792-4373

Stephen Friedkin, MD	Susan Dugoni, MD	_____	_____
Patrick Burke, MD	Sara Dobbs, MD	_____	_____
Krista Amendola, MD	Dennis Unson, MD	Physician's signature	Date
Marjorie Alpert, MD			

_____ In my opinion it would be beneficial to discuss this further and request the school nurse to contact me.