ISBVI Medical Update and Physical Exam Form
Academic Year 2021-2022

To Be Completed By Parent/Guardian

Name: _____ Gender: _____ Date of Birth: _____

Grade: _____

1. Does your child have asthma? Yes_____ No_____ If **YES**, please answer the following:
   A. Does your child have a rescue inhaler? Yes_____ No_____ If **YES**, please provide one for use in the health center.
   B. Does your child have an Asthma Action Plan from a medical provider? Yes_____ No_____ If **YES**, please provide a copy for your child's chart.
2. Does your child have a severe allergy (one that would cause an **anaphylactic reaction**)? Yes_____ No_____ If **YES**, please answer the following:
   A. What are your child's allergens? _____
   B. Does your child require an Epi-Pen? Yes_____ No_____ If **YES**, please provide an MD order and medication.
   C. Does your child have an Allergy Action Plan from a medical provider? Yes_____ No_____ *****An action plan filled out by your child's doctor must be on file in the health center if your child is required to have an Epi-Pen.
3. Does your child have a history of seizures? Yes_____ No_____ If **YES**, please answer the following:
   A. Date of last seizure? _____
   B. Does your child have Diastat (Diazepam Rectal Suppository) prescribed? Yes_____ No_____
   If **YES**, please provide an MD order and medication.
   C. Does your child have a Seizure Action Plan? Yes_____ No_____ *****An action plan filled out by your child's doctor must be on file in the health center if your child has a seizure disorder.
4. Cerebral Shunt? Yes_____ No_____ If **YES**, left or right? _____
5. Eye condition(s)? _____
6. Other medical conditions health center should be aware of? _____
   _____
7. Orthotics, Braces, Prosthetics? Yes_____ No_____ If YES, please list:_____
   _____
8. Hospitalizations (include dates)_____
9. Surgeries (include dates)_____
10. Current Medications:_____
11. Allergies? (ones not listed as severe above) _____
12. Activity Restrictions? Yes____ No _____ If YES, please detail_____
13. Diet Restrictions? Yes_____ No_____ If YES, please detail_____
14. Glasses or contacts? Yes_____ No_____

Did your child receive any of the following this summer? If **YES**, please provide documentation from a health care provider.

Immunizations?	Yes_____	No_____
Physical Exam?	Yes_____	No_____
Eye Exam?	Yes_____	No_____

Please provide a current immunization record from your child's health care provider.

Parent/Guardian Signature: _____ Date: _____

To Be Completed by A Licensed Health Care Provider

PHYSICAL EXAMINATION

Name:_____

Date of Examination: _____ Ht: _____ Wt: _____ BP: _____ Pulse: _____

Eyes: _____ Heart: _____ Neuro: _____

Ears: _____ Abdomen: _____ Spine: _____

Nose: _____ Lymph nodes: _____ Extremities: _____

Throat: _____ Genitourinary: _____ Skin: _____

Lungs: _____ Hernia: _____ Emotional Status: _____

Comments:

Physical Education Activity Restrictions? Yes_____ No_____

If **YES**, please list restriction: _____

Other notes: _____

_____

Provider's Signature: _____ Date: _____

Printed Name: _____

Address: _____ Phone: _____