

ISBVI Medical Update and Physical Exam Form
Academic Year 2023 – 2024

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. Does your child have a cerebral shunt? Yes _____ No _____ If YES, left or right? _____
5. Eye condition(s)? _____
6. Other medical conditions the 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: _____

ISBVI Medical Update and Physical Exam Form
Academic Year 2023 – 2024

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(s): _____

Other notes: _____

Provider's Signature: _____

Date: _____

Printed Name: _____

Address: _____

Phone: _____