

HEALTH HISTORY UPDATE

Name: _____ Gender: _____ D.O.B _____
 (last) (first)

Grade: _____ Parent's/Guardian's: _____
 (last) (first)

Family Physician: _____ Family Dentist: _____

STATEMENT OF HEALTH IN OWN WORDS _____

Check Any of The Following You May Have Had Or Are Now Troubled With

	yes	No	When		Yes	No	When
Mental Illness				Asthma			
Joint Problems				Frequent Indigestion			
Tuberculosis				Kidney Trouble			
Infectious Hepatitis				Diabetes			
Migraines				Seizures			
Frequent Headaches				Heart Trouble			
Cancer				High Blood Pressure			
Frequent Nosebleeds				Arthritis			
Acne				Other skin conditions			

Specify Any Illness, Surgery, Or Injury Not Mentioned Above: _____

Have You Had A Tuberculin Skin Test with In the last year? Yes No Date _____ Results _____

Are you taking any medication: Yes No Name of Medication(s): _____

Why are you taking this medication(s) _____

When do you take this medication(s) _____

Allergies: Bee Stings Yes No / Medication Yes No / Food Yes No / Animal Yes No

List specific allergy: _____

What, if any, medications are taken for known allergies _____

Please complete and return to:

ST. ALOYSIUS SCHOOL
 2401 S. Main Avenue
 Kaukauna, WI. 54130



THE KAUKAUNA CATHOLIC SCHOOL SYSTEM
 ST. ALOYSIUS SCHOOL
 2401 S. Main Avenue
 Kaukauna, Wi. 54130

STUDENT HEALTH EXAMINATION OPTIONAL

I. _____
 (Student's Name) (D.O.B.) (School) (Grade)

_____ (Address) _____ (Parent/Guardian) _____ (Phone)

II. TO BE COMPLETED BY PHYSICIAN
 PHYSICAL EXAMINATION

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

LABORATORY TESTS (PER DISCRETION OF PHYSICIAN)

	NORMAL	ABNORMAL
Skin		
Eyes		
Vision:		
Ears		
Audiometric:		
Nose & Throat		
Mouth		
Dental		
Neck		
Heart		
Lungs		
Abdomen		
Hernia		
Extremities		
Scoliosis		
Nutritional Status		

	RESULTS
Urine: Protein	
P.H.	
Sugar	
Specific Gravity	
Culture	
Blood: Hemoglobin	
Hematocrit	
Other (specify)	
T.B. Test Type	
Lead Screening	
Other: Specify	

COMMENTS: _____

III. IMMUNIZATIONS GIVEN AT THIS EXAM _____

IV. Is this child on routine medication? _____ If so what? _____

Why? _____

Does this child have any problems with bowel or bladder control? _____

Do you wish to see this child again? _____ When? _____

Are you referring this child to another professional? _____

If so whom? _____

(OVER PLEASE)

RECOMMENDATION FOR CHILD'S SCHOOL PROGRAM

Does this child have any specific health needs which should be addressed during the school day?

II. RECOMMENDATION FOR PHYSICAL EDUCATION

_____ Full activity

_____ Restricted Activity

EXPLAIN: _____

Date of examination: _____ Signature of Physician _____

Address _____ Phone _____

Please send completed exam to:

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