PCM Schools

Prairie City Elementary
309 E. Plainsmen Road Box 490 Prairie City, Iowa 50228
Ph. 515-994 2377 Fax. 515-994-3342

Monroe Elementary
400 N. Jasper Box 610 Monroe, Iowa 50170
Ph 641-259-2314 Fax 641-259 2944

Student ____

Female **Male** **Date of birth** _______________

Medical and Health History

History	**Date**	**Comments**	
Prenatal/Birth			
Allergies		To Medication_________________ To Food_________________ To Latex_____ **Epi-pen** ❑ Yes ❑No	
Asthma			
Medications			
Illness, serious			
Chickenpox		○ Immunization	○ Natural disease
Injury, serious			
Hospitalization/ Surgery			
Immunizations		Attach current immunization record	
Other			

Parent's Statement on Sharing of Information:
Information on this form is confidential and will be filed in the school nurse's office. I acknowledge that the information noted on this form will be shared with school staff members only on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature _________________________________

Date __________

Physical Exam and Assessment
By Physician, Nurse Practitioner or Physician Assistant

Date of exam: _________________
Height _______ Weight ________ Blood pressure __________
Vision: Both 20/____ Right 20/_____ Left 20/_______

System	**WNL**	**Comments**
Skin		
Eyes		Referred?
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Spinal		**Scoliosis Screening** WNL____ Referred____
Neurologic		
Emotional/social		
Lead screening (required)		**Date:** **Results:**
Dental screening (required):		**Referred? State Dental Form Required**
Labs if indicated		
TB risk		Mantoux if indicated
Health conditions requiring intervention/modification at school:		
Physical Education Program: Full______ Limited_______ None______ Reason		

Examined by (print) ______________________________
Signature ___________________________ **Date** __________
Clinic __________________________ **Phone** ______________