Print Form

Reset Form

CASTRO VALLEY UNIFIED SCHOOL DISTRICT

4400 Alma Avenue, Castro Valley, CA 94546 (510) 537-3000

HEALTH SERVICES – HEALTH HISTORY & PHYSICAL EXAMINATION

STUDENT INFORMATION

Student Legal Last Name: **First Name** **Middle Name:**

School: **Gender** ☐ **M** ☐ **F** **Date of Birth:**

TO BE COMPLETED BY PARENT

CURRENT HEALTH STATUS (IF APPLICABLE)

☐ **Diet or nutritional problems** ☐ **Hearing difficulties, infections** ☐ **Speech difficulties**

☐ **Frequent colds or sore throats** ☐ **Pains in extremities or joints** ☐ **Vision – wears glasses during the school day**

☐ **Frequent headaches** ☐ **Special or poor eating habits** ☐ **Weight problem/risk of/have type II diabetes**

Further explanation of above items:

Dental Condition: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Wears braces or appliance**

Currently under the care of dentist: **YES**☐ **NO**☐ **:** (NAME AND PHONE #):

Currently under the care of physician: **YES**☐ **NO**☐ **:** (NAME AND PHONE#):

If yes, for what condition:

MEDICATION: Please indicate the names and dose of all meds (including over the counter meds) your child takes regularly

Name of Medication	Dosage (how much)	Times Given

PARENT NOTIFICATION

I STATE THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO BE BEST OF MY KNOWLEDGE.

Parent Signature: **Date:**

The CVUSD is part of the California Immunization Registry. This registry is called CAIR. Keeping track of your child's shots/TB tests can be hard, especially if more than one doctor gave them. Please see page two of this form to grant the CVUSD permission to share shot records with the CAIR registry. Thank you.

PHYSICIAN'S EXAMINATION : HEALTH HISTORY

☐ **ADHD**	☐ **Cancer**	☐ **Epi-pen**	☐ **Kidney/Bladder**	☐ **Seizure Disorder**
☐ **Allergies (list below)**	☐ **Convulsive Disorder**	☐ **Hearing Aide/Tubes**	☐ **Menstrual Problem**	☐ **Skin Problem**
☐ **Asthma**	☐ **Cystic Fibrosis**	☐ **Hearing Problem**	☐ **Migraine Headaches**	☐ **Stomach Problem**
☐ **Asthma Inhaler**	☐ **Diabetes**	☐ **Heart Problem**	☐ **Muscular Dystrophy**	☐ **Thyroid Condition**
☐ **Bee Sting allergy**	☐ **Ear Infections**	☐ **Hernia**	☐ **Musculo-Skeletal**	☐ **Tourette Syndrome**
☐ **Food Restrictions (medical/non medical)**	☐ **Eating Disorder**			
List:	☐ **Other:**		☐ **Physical Handicap**	☐ **Urinary Condition**

Surgeries or accidents: **Eye or ear surgery, fractures, head injuries.** **Dates:**

Brief explanation:

COMPLETE	*IMMUNIZATION HISTORY	START DATE	BOOSTER DATE	BOOSTER DATE	BOOSTER DATE
☐	***Diphitheria/Pertusis/Tetanus**	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR
☐	**Tdap/DTaP/DTP (> than 7yrs)**	DAY/MONTH/YEAR	DAY/MONTH/YEAR		
☐	**Polio**	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR
☐	**Measles/Mumps/Rubella**	DAY/MONTH/YEAR	DAY/MONTH/YEAR		
☐	**Hepatitus B**	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR	
☐	**Hepatitus A**	DAY/MONTH/YEAR	DAY/MONTH/YEAR		
☐	**HIB Meningitis**	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR	DAY/MONTH/YEAR
☐	**Varicella (chicken pox)**	DAY/MONTH/YEAR	DAY/MONTH/YEAR		
☐	***Tuberculin skin test results:**	**NEG** ☐ **POS** ☐	**DATE:**	**BCG Vaccine DATE:**	
	Chest X-ray results:	**NEG** ☐ **POS** ☐	**DATE:**	**Follow Up:**	**Meds:Yes** ☐ **No** ☐

LABORATORY TEST RESULTS	Hematocrit:	Hemoglobin:	Urinalysis:	Blood pressure:	Other:

Please consider dental condition, EENT, heart, lungs, abdomen, neurological reflexes, behavior, emotional adjustment in *

***SIGNIFICANT FINDINGS:**

SIGNIFICANT DIAGNOSTIC EVALUATION, OBSERVATION, RECOMMENDATIONS:
(Special education services are available to children with handicapping conditions or special needs):

Recommendations for Physical Activity: ☐ **Unrestricted** ☐ **Restricted: length of time:** **Athletic Participation** ☐ **Yes** ☐ **No**

PHYSICIAN'S INFORMATION AND STATEMENT

You should complete and sign the Physician's Statement based on your examination of the patient
As of this date, I certify that the statements contained in this statement of examination are true to the best of my knowledge and belief.

Physician's Name & Stamp:		**Address:**	
Signature:		**Date of Exam**	

To satisfy CHDP requirements a complete and current physical examination, including starred (*) items, should be given. This can be done any time within the six months prior to entering Kindergarten.

CVUSD: Rev 2.2014