Missouri Valley CSD Elementary
602 N 9th St, Missouri Valley, IA 51555
Ph. 712-642-2279 Fax 712-642-2656

Student _____

Female **Male** **Date of Birth**_____

Parent/Guardian Name _____

Medical and Health History

History	Date	Comments
Prenatal/Birth		
Allergies		To Medication _____ To Food _____To Latex_____ **Epi-pen** ☐ Yes ☐ No
Asthma		
Seizures		
Medications		
Illness, serious		
Injury, serious		
Chickenpox		☐ Diagnosed ☐ By report
Hospitalization/ Surgery		
Immunizations Attach IRIS form	☐ Up to date for school entry ☐ Boosters needed:	
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 wil be shared with school staff memebers only on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature _____
Date _____

NOTE: IMMUNIZATIONS CERTIFICATE, DENTAL CERTIFICATE, PROOF OF LEAD SCREENING AND PHYSICAL ARE REQUIRED BEFORE ATTENDING SCHOOL.

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/_____
Hearing: **Right Ear** Pass _____ Fail _____ **Left Ear** Pass _____ Fail _____

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		

Health condiditons requiring intervention/modification at school:

Physical Education Program: **Full** _____ **Limited** _____ **None** _____
Reason:

Examined by (print) _____

Signature _____ **Date**_____

Clinic _____ **Phone** _____