Dear parents/guardians of incoming freshman and transfer students:

We are looking forward to having your student join us at GBN! Please read the following requirements carefully. Attached are important health forms for completion to be returned as soon as possible. Please note due dates. If forms are already completed or will be completed prior to the due date, please send them in prior to the due date.

<table>
<thead>
<tr>
<th>Health Form Due Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1, 2020</td>
</tr>
<tr>
<td>August 19, 2020</td>
</tr>
<tr>
<td>October 15, 2020</td>
</tr>
<tr>
<td>May 15, 2021</td>
</tr>
</tbody>
</table>

---

**Physical Exam on State of Illinois Certificate of Health Examination Form and Immunization Record**

- Acceptable if dated within 12 months from the first day of school (dated August 19, 2019 or after).
- Please fill out and sign parent/guardian health history section and note any health conditions, disabilities, allergies, and medications.

**Medication Authorization Forms:**
- TYLENOL/ADVIL PERMISION
- PRESCRIPTION MEDICATIONS

- Tylenol and Advil are stocked in the health office and may be given as needed with a completed TYLENOL/ADVIL Authorization Form.
- Parent/guardian AND medical provider signatures are required.
- Prescription and other over the counter medications to be dispensed during the school day require a completed PRESCRIPTION Medication Authorization Form. This form must be submitted annually and when a prescription has changed.

**Care Plans**
- Allergy, Asthma, Diabetes, Seizure and other medical conditions

- Annual updated care plans and health updates are required for students with chronic health conditions.
- Some common care plans are available on the GBN website at [https://gbn.glenbrook225.org/Offices/Nurse](https://gbn.glenbrook225.org/Offices/Nurse) and are also available in the health office. If your student’s physician has their own care plan for schools, we are happy to accept it.

**Dental Examination Form**

- Dental Exam due for ALL Freshman Students, acceptable if dated on or after November 15, 2019
- Illinois law requires all students transferring to an Illinois School for the first time from out of state, to complete an eye exam. Please bring the attached form to the eye doctor and return it to the GBN health office.

---

- All health forms are available for download at [https://gbn.glenbrook225.org/Offices/Nurse](https://gbn.glenbrook225.org/Offices/Nurse)
- Forms may be submitted by mail, fax, dropped off at GBN, or emailed to: GBNhealthoffice@glenbrook225.org
- Please keep a copy for your records.

Thank you,
The Glenbrook North Nursing Staff

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Rev. 2/2020
State of Illinois
Illinois Department of Public Health

Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name

Birth Date (Month/Day/Year)  Gender  Grade

Parent or Guardian

Phone (Area Code)

Address (Number) (Street) (City) (ZIP Code)

County

To Be Completed By Examining Doctor

Case History

Date of exam

Ocular history: ☐ Normal or Positive for

Medical history: ☐ Normal or Positive for

Drug allergies: ☐ NKDA or Allergic to

Other information

Examination

<table>
<thead>
<tr>
<th>Distance</th>
<th>Near</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Left</td>
<td>Both</td>
<td>Both</td>
</tr>
<tr>
<td>Uncorrected visual acuity</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
</tr>
<tr>
<td>Best corrected visual acuity</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

Was refraction performed with dilation? ☐ Yes ☐ No

External exam (lids, lashes, cornea, etc.) ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Internal exam (vitreous, lens, fundus, etc.) ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Pupillary reflex (pupils) ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Binocular function (stereopsis) ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Accommodation and vergence ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Color vision ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Glaucoma evaluation ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Oculomotor assessment ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

Other ☐ Normal ☐ Abnormal ☐ Not Able to Assess ☐ Comments

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

☐ Normal  ☐ Myopia  ☐ Hyperopia  ☐ Astigmatism  ☐ Strabismus  ☐ Amblyopia

Other

Continued on back
Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:
   ☐ Constant wear ☐ Near vision ☐ Far vision
   ☐ May be removed for physical education

2. Preferential seating recommended: ☐ No ☐ Yes
   Comments ________________________________________________________________

   ________________________________________________________________

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months
   ☐ Other __________________________________________

4. ________________________________________________________________

5. ________________________________________________________________

Print name ________________________________
Optometrist or physician (such as an ophthalmologist)
who provided the eye examination ☐ MD ☐ OD ☐ DO
License Number ________________________________

Consent of Parent or Guardian
I agree to release the above information on my child
or ward to appropriate school or health authorities.

(Parent or Guardian’s Signature)

(Date)

Address ________________________________________________________________

Phone ________________________________________________________________

Signature ________________________________________________________________ Date __________________

(Source: Amended at 32 Ill. Reg. __________, effective __________)
Glenbrook High School District 225
Glenbrook North High School
Glenbrook South High School

School Medication Authorization Form
PRESCRIPTION MEDICATIONS

Student Name

ID#

Illinois State Law requires written permission by a parent/guardian and licensed healthcare provider for administration of any medication at school. Please complete the following information and have your child’s physician provide the appropriate instructions and signatures at the bottom of this form. **Prescription medication orders must be renewed annually.** Parents are responsible for providing the school with all medications in the original prescription-labeled, or manufacturer-labeled bottle.

**Asthma/Allergies/Diabetes:**
Students with asthma or severe allergies are strongly encouraged to carry their rescue inhalers or Epi-pens on their person. Back-up medications may also be stored in the Health Office/Nurse’s Office, and is highly encouraged, so that they are readily available in the event of an emergency. Additionally, a nebulizer is available for use with a valid doctor’s order. Diabetic students may keep a supply of insulin, syringes, and a glucometer in the Health Office/Nurse’s Office for their use, along with any other needed testing supplies. Most diabetic students keep their supplies in a plastic box labeled with their name and ID number. Diabetic students may store food or snacks in the refrigerator. Please make every effort to supply the Health Office/Nurse’s Office with your child’s most current Care Plan.

**PRESCRIPTION MEDICATIONS**

<table>
<thead>
<tr>
<th>Medication Name and Dosage:</th>
<th>Medication Name and Dosage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency/Instructions:</td>
<td>Frequency/Instructions:</td>
</tr>
<tr>
<td>Diagnosis/Indication:</td>
<td>Diagnosis/Indication:</td>
</tr>
<tr>
<td>Possible Side Effects:</td>
<td>Possible Side Effects:</td>
</tr>
</tbody>
</table>

**Parent/Guardian & Physician Authorization**

I authorize Glenbrook High School District 225 to administer said medications to my child, on an as needed basis, according to School Board Policy and Medication Administration Procedures and Guidelines.

Parent/Guardian Signature __________________________________________ Date __________

Physician Signature __________________________________________ Date __________

Physician’s Name (Printed) _________________________________ Date __________
For parents/guardians of students who need to carry and use their asthma medication (rescue inhaler) or epinephrine auto-injector:

I authorize Glenbrook School District 225 and its employees and agents, to allow my child or ward to self-carry and self-administer his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois Law requires the school district to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student’s self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30).

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian initials ______________________

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize School District 225 and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State Law, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors or opioid antagonists to my child when, in good faith, it is believed my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and

I agree to indemnify and hold harmless Glenbrook School District 225 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of said administration, or the child’s self-administration of medication.

Parent/Guardian Name (Printed) ____________________________________________________________

Parent/Guardian Signature _________________________________________________________________

Primary Phone Number: ________________________________________________________________

Emergency Phone Number: ______________________________________________________________
Illinois State Law requires written permission by a parent/guardian and licensed healthcare provider for administration of any medication at school. Please complete the following information, circle your preference of which over-the-counter medication(s) you would like your child to have permission to take, while at school, and provide the appropriate signatures at the bottom of this form. This form will be kept on file in the Health Office/Nurse’s Office and will be valid until graduation.

Student Name: ________________________ ID# __________________

Tylenol or Advil Permission

Please circle which medication you would like your child to have permission to take during the school day. The Health Office stocks a generic supply of the medications listed below (acetaminophen and ibuprofen).

Tylenol 325mg 1-2 tablets
(Every 6 hours as needed)

Advil 200mg, 1-2 tablets
(Every 6 hours as needed)

Tylenol 500mg (Extra strength) 1-2 tablets
(Every 6 hours as needed)

Parent/Guardian & Physician Authorization

I authorize Glenbrook High School District 225 to administer said medications to my child, on an as needed basis, according to School Board Policy and Medication Administration Procedures and Guidelines.

Parent/Guardian Signature __________________________________________ Date __________

Physician Signature __________________________________________ Date __________

Physician’s Name (Printed) __________________________________________ Date __________
PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 16 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

<table>
<thead>
<tr>
<th>Student's Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birth Date: (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street</td>
<td>City</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Name of School:</td>
<td>ZIP Code</td>
<td>Grade Level:</td>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Parent or Guardian:</td>
<td>Last Name</td>
<td>First Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student's Race/Ethnicity:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ White</td>
<td>☐ Black/African American</td>
<td>☐ Hispanic/Latino</td>
<td>☐ Asian</td>
<td></td>
</tr>
<tr>
<td>☐ Native American</td>
<td>☐ Native Hawaiian/Pacific Islander</td>
<td>☐ Multi-racial</td>
<td>☐ Unknown</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To be completed by dentist:

Date of Most Recent Examination: ____________________________

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No Dental Sealants Present on Permanent Molars

☐ Yes ☐ No Caries Experience / Restoration History — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No Untreated Caries — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ Restorative Care — amalgams, composites, crowns, etc. Appointment Date: ____________________________

☐ Preventive Care — sealants, fluoride treatment, prophylaxis Appointment Date: ____________________________

☐ Pediatric Dentist Referral Recommended Treatment Completion Date: ____________________________

Additional comments: ____________________________

Signature of Dentist ____________________________ License #: ____________________________ Date: ____________________________

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

IOCI 0800-10 Printed by Authority of the State of Illinois
# State of Illinois
## Certificate of Child Health Examination

### Student's Information

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School/Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Address Information

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
<th>Parent/Guardian</th>
<th>Telephone #</th>
<th>Home</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Immunizations

**IMMUNIZATIONS:** To be completed by health care provider. The mo/dy/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

### Required Vaccine / Dose

<table>
<thead>
<tr>
<th>REQUIRED Vaccine / Dose</th>
<th>DOSE 1</th>
<th>DOSE 2</th>
<th>DOSE 3</th>
<th>DOSE 4</th>
<th>DOSE 5</th>
<th>DOSE 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tdap, Td or Pediatiric DT (Check specific type)</td>
<td>□ Tdap □ Td □ DT</td>
<td>□ Tdap □ Td □ DT</td>
<td>□ Tdap □ Td □ DT</td>
<td>□ Tdap □ Td □ DT</td>
<td>□ Tdap □ Td □ DT</td>
<td></td>
</tr>
<tr>
<td>Polio (Check specific type)</td>
<td>□ IPV □ OPV</td>
<td>□ IPV □ OPV</td>
<td>□ IPV □ OPV</td>
<td>□ IPV □ OPV</td>
<td>□ IPV □ OPV</td>
<td>□ IPV □ OPV</td>
</tr>
<tr>
<td>Hib Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR Measles Mumps Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** * indicates invalid dose

### Recommended, But Not Required Vaccine / Dose

- Hepatitis A
- HPV
- Influenza
- Other: Specify
  - Immunization
  - Administered/Dates

**Health Care Provider (MD, DO, APN, PA, School Health Professional, Health official) verifying above Immunization history must sign below.**

If adding dates to the above Immunization history section, put your initials by date(s) and sign here.

**Signature**

**Title**

**Date**

### Alternative Proof of Immunity

1. **Clinical Diagnosis** (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
   
   *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR*

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
   
   Person signing below verifies that the parent/guardian’s description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

   **Date of Disease**

   **Signature**

   **Title**

3. **Laboratory Evidence of Immunity (check one)**
   
   □ Measles* □ Mumps** □ Rubella □ Varicella
   
   Attach copy of lab result.

   *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
   **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:**

**Physician Statements of Immunity MUST be submitted to IDPH for review.**

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and **Maintained** by the School Authority.

11/2015

(COMplete BOTH SIDES)
**HEALTH HISTORY**

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

<table>
<thead>
<tr>
<th>ALLERGIES</th>
<th>MEDICATION</th>
<th>YES</th>
<th>NO</th>
<th>List:</th>
<th>YES</th>
<th>NO</th>
<th>List:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of asthma?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Loss of function of one paired organs? (eye/ear/kidney/testicle)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Child wakes during night coughing?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth defects?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Hospitalizations?</td>
<td>When? What for?</td>
<td>Yes</td>
</tr>
<tr>
<td>Developmental delay?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood disorders? Hemophilia, Sickle Cell, Other? Explain</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Surgery? (List all.)</td>
<td>Where? What for?</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Serious injury or illness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head injury/Concussion/Passed out?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>TB skin test positive (past/present)?</td>
<td>Yes* No*</td>
<td>*If yes, refer to local health department.</td>
</tr>
<tr>
<td>Seizures? What are they like?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>TB disease (past or present)?</td>
<td>Yes* No*</td>
<td></td>
</tr>
<tr>
<td>Heart problem/Shortness of breath?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Tobacco use (type, frequency)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Alcohol/Drug use?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>Family history of sudden death before age 50? (Cause?)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Eye/Vision problems?**
- Glasses
- Contacts
- Last exam by eye doctor

**Other concerns?** (crossed eye, drooping lids, squinting, difficulty reading)

**Ear/Throat problems?**

**Bone/Joint problem/injury/scoliosis?**

**PHYSICAL EXAMINATION REQUIREMENTS**

<table>
<thead>
<tr>
<th>Entire section below to be completed by MD/DO/APN/PA</th>
</tr>
</thead>
</table>

**HEAD CIRCUMFERENCE** if < 2-3 years old

**HEIGHT**
- WEIGHT
- BMI
- BMI PERCENTILE
- B/P

**DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)**
- BMI > 85% age/sex
- Ethnic Minority
- Signs of Insulin Resistance (hypertension, dyslipidemia, poly cystic ovarian syndrome, acanthosis nigricans)

**LEAD RISK QUESTIONNAIRE**
- Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
- (Blood test required if resides in Chicago or high risk zip code.)

**TB SKIN OR BLOOD TEST**
- Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines: http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.
- No test needed
- Test performed
- Skin Test: Date Read
  - Result: Positive
  - Negative
- mm
- Blood Test: Date Reported
  - Result: Positive
  - Negative
- Value

**LAB TESTS (Recommended)**
- Date
- Results
- Sickle Cell (when indicated)
- Date
- Results

**SYSTEM REVIEW**
- Normal
- Comments/Follow-up/Needs
- Normal
- Comments/Follow-up/Needs
- Skin
- Endocrine
- Ears
- Screening Result: Gastrointestinal
- Eyes
- Screening Result: Genito-Urinary
- LMP
- Nose
- Neurological
- Throat
- Musculoskeletal
- Mouth/Dental
- Spinal Exam
- Cardiovascular/HTN
- Nutritional status
- Respiratory
  - Diagnosis of Asthma
  - Mental Health
  - Other

**NEEDS/MODIFICATIONS** required in the school setting

**DIETARY Needs/Restrictions**

**MENTAL HEALTH/OFFICE**
- Is there anything else the school should know about this student?
- If you would like to discuss this student's health with school or school health personnel, check title: Nurse
  - Teacher
  - Counselor
  - Principal

**EMERGENCY ACTION**
- needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
- Yes
- No
- If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in

**PHYSICAL EDUCATION**
- Yes
- No
- Modified
- INTERSCHOLASTIC SPORTS
  - Yes
  - No
  - Modified

**Print Name**
(MD, DO, APN, PA)

**Signature**

**Date**

**Address**

**Phone**