South Bend Community School Corporation
School Entry Physical Examination

TO BE COMPLETED BY PARENT

Student's name (*last, first*) ______________________________ Birth date ___/___/_______

Sex: [ ] M [ ] F Street address ______________________ School_______________ Grade_______

Parent/Guardian name ______________________________ Home phone ___________________

Check health conditions below that affect your child.

[ ] ADD/ADHD
[ ] allergies
[ ] asthma
[ ] bee sting allergy
[ ] chickenpox (date ______)
[ ] cystic fibrosis
[ ] diabetes
[ ] food allergy
[ ] G.I. disorder
[ ] hearing loss
[ ] heart condition
[ ] kidney disorder
[ ] malignancy
[ ] neurological disorder
[ ] seizures
[ ] sickle cell anemia
[ ] visual impairment
[ ] other ______________________
____
____

HAS YOUR CHILD BEEN SCREENED FOR LEAD? (Yes/No) If no, SBCSC requires a lead screening prior to school enrollment! Ask your health care provider or contact the St. Joseph County Health Department for information about lead screening @ **574-235-9582**.

Give a brief history of serious accidents, surgeries and/or health conditions of your child: ________________

____

List medication your child is taking regularly: ____________________________________

____

Parent/Guardian signature ______________________________________ **Date** ___________

TO BE COMPLETED BY PHYSICIAN

HT ______ WT ______ B/P _________ LEAD TEST: Date___/___/___ [ ] capillary or [ ] venous Result ________

	NORM.	*ABNORM.*	*REMARKS*
Eyes			Vision: RT LT
ENT			
Lungs			
Heart			
Abdomen			
Hernia			
Extremities			
Neuro			
Skin			

Other conditions/disabilities: ____

Urine *(if applicable)*: Alb ____ Sugar ____

Should child be restricted from any activities, including PE and recess? [ ] yes [ ] no If yes, explain. ___________

____

Healthcare Provider (Print) ______________________________________

Healthcare Provider signature ______________________________________ Date ____________

South Bend Community School Corporation

School Entry Physical Examination

ESTA SECCIÓN DEBE SER COMPLETADA POR UN/A PADRE/MADRE/GUARDIÁN LEGAL

Nombre del estudiante (apellido/s, nombre) ______________________________ Fecha de nacimiento ____/____/_____

GÉNERO F M Domicilio____ Escuela ___________________ Grado _______

Nombre de padre/madre/guardián legal ____ Teléfono __________________

Marque las condiciones de salud que hayan afectado a su hijo/a.

[ ] ADD/ADHD
[ ] alergias
[ ] asma
[ ] alergia a picadura de abeja
[ ] varicela (fecha ______)
[ ] fibrosis quística
[ ] diabetes
[ ] alergia a comida
[ ] trastorno gastrointestinal
[ ] pérdida de audición
[ ] condición cardíaca
[ ] trastorno renal
[ ] malignidad
[ ] trastorno neurológico
[ ] convulsiones
[ ] anemia falciforme
[ ] impedimento visual
[ ] otro ______________
____
____

¿SU HIJO/A HA SIDO EXAMINADO/A PARA DETECTAR PLOMO? (Sí/No) Si la respuesta es no, ¡SBCSC requiere un examen de plomo antes de inscribirse en la escuela! Pregúntele a su proveedor de cuidado de saludo, o comuníquese con el Departamento de Salud del Condado de St. Joseph llamando al **574-235-9582** para recibir información acerca del examen de plomo.

Escriba un breve resumen de serios accidentes, cirugías, y/o condiciones de salud que haya tenido su hijo/a: ________

____

Escriba el nombre de medicamentos que su hijo/a toma regularmente: ________________________________

____

Firma de padre/madre/guardián legal: ____ **Fecha:** ____________________

TO BE COMPLETED BY PHYSICIAN

HT ______ WT ______ B/P _________ LEAD TEST: Date___/___/___ [ ] capillary or [ ] venous Result ________

	NORM.	*ABNORM.*	*REMARKS*
Eyes			Vision: RT LT
ENT			
Lungs			
Heart			
Abdomen			
Hernia			
Extremities			
Neuro			
Skin			

Other conditions/disabilities: ____

Urine *(if applicable)*: Alb ____ Sugar ____

Should child be restricted from any activities, including PE and recess? [ ] yes [ ] no If yes, explain. ___________

____

Healthcare Provider (Print) ____

Healthcare Provider signature ____ Date _____________