



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.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> cystic fibrosis | <input type="checkbox"/> heart condition | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> allergies | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disorder | <input type="checkbox"/> visual impairment |
| <input type="checkbox"/> asthma | <input type="checkbox"/> food allergy | <input type="checkbox"/> malignancy | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> bee sting allergy | <input type="checkbox"/> G.I. disorder | <input type="checkbox"/> neurological disorder | _____ |
| <input type="checkbox"/> chickenpox (date _____) | <input type="checkbox"/> hearing loss | <input type="checkbox"/> seizures | _____ |

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

¿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 salud, 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

Table with 4 columns: NORM., ABNORM., REMARKS, and a blank column. Rows include Eyes, ENT, Lungs, Heart, Abdomen, Hernia, Extremities, Neuro, and 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