EAST ARKANSAS MEDICAL CLINIC

901 Holiday Dr, Forrest City, Arkansas 72335 Phone: 870-633-0880

HEALTH HISTORY PHYSICAL FORM

STUDENT NAME:	BIRTHDAY	SCHOOL
Father/Guardian Name	Mother/Guardian Name:	Phone Number
Dentist Name:	Address:	Phone Number:

TO BE COMPLETED BY PARENT/GUARDIAN (PLEASE CIRCLE ONE):

1. Does your child pay attention when being read to? Yes No
2. Can your child play quietly alone for over ½ hour? Yes No
3. Does your child mind adults and follow instructions? Yes No
4. Does your child speak clearly enough for others to understand? Yes No
5. Does your child object to being left with a sitter? Yes No
6. Can your child dress without help? Yes No
7. Does your child have any speech problems? Yes No
8. Does your child ever wet or soil him/herself during the day? Yes No
9. Do you have any concerns about your child 's general health (Eating and sleeping habits, bowel or bladder, posture, teeth, Skin, weight, etc) ? Yes No
10. Does your child have any eye problems (difficulty seeing, crossed eyes Frequently reddened or watery eyes, wear glasses or contacts)? Yes No

11. Does your child have any ear or hearing problems (frequent earaches, Difficulty hearing, draining ears, use a hearing aid, etc.)? Yes No

12. Does your child have any allergies (food, insects, drugs, pollen, etc.)? Yes No

13. Does your child have any specific sickness which might in your opinion Affect his school performance or program? Yes No

    (a) Has your child received any medical or other evaluations, The findings of which could help school personnel in meeting his/ her health or educational needs? Yes No
    (b) Does this problem require any health care in the school? Yes No
    (c) Does your child take medications? Yes No

14. Do you have any concern about your child's developmental behavior Or emotional well-being of which the school should be aware? Yes No

IF YOU ANSWERED YES TO QUESTIONS 7-14 PLEASE DESCRIBE THE PROBLEM OR CONCERN YOU HAVE BELOW:

Question Number	Description

Information on this form may be shared with appropriate personnel for health and educational purposes

Parent's Signature _____ Date _____

East Arkansas Children's Clinic
901 Holiday Drive
Forrest City, AR 72335

Child's Name: _____

School: _____

BP: ___/___
WT: ____
HT: ___' ___"

	NL	ABNL	COMMENTS:
SKIN: color, rash, swelling, hair nails			
EYES: conjunctive, cornea, pupils, extracular movement			
EARS: pirnae, canals, tyromanic membrane appearances			
NOSE: nares, turbinates			
MOUTH: tongue, teeth, oral mucossa, tonsils, pharynx			
NECK: thyroid, range of motion			
NODES: cervical, axillary, inquinal, other			
HEART: rate, rhythm, S1, S2, murmur, femoral pulses			
CHEST: resp. rate, retractions, auscultation			
ABDOMEN: contour, palpation of liver, spleen, kidney, mass, hernia			
GENITA-URINARY: female external; male penis, meatus, testes, hernia			
MUSCULOSKELETAL: range of motion, tenderness, edema, clubbing, spine (curvature)			
DEVELOPMENTAL			
GROSS MOTOR			
FINE MOTOR			
SOCIAL			
SPEECH/LANGUAGE			

	DATE	NL	ABNL RESULT
HEMOGLOBIN			
HEMATOCRIT			
URINALYSIS			
OTHER:			

MEDICATIONS: _____

DIET RESTRICTIONS: _____

SPECIAL EQUIPMENT: _____

ALLERGIES: _____

GENERAL COMMENTS OR RECOMMENDATIONS:

_____

_____

_____

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

_____ _____
Signature of Health Provider Date Signed

_____ _____
Phone # Date of Exam

Please return to school office as soon as this form is completed.

Edited: 1/27/07