ARROWHEAD HIGH SCHOOL - HISTORY & PHYSICIAN PHYSICAL FORM
TO BE COMPLETED BY PHYSICIAN OF ALL FRESHMAN & NEW STUDENTS!

Name (Last) _____ (First) _____ (Middle Initial) _____ Birth Date _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Have MD complete at annual physical!
Mail back: Kristi Kirk RN, 700 North Ave, Hartland, WI 53029

HEALTH HISTORY:

Yes **No** **Please explain all yes answers and list current treatment medications! (Use back if more space is needed)**

☐ ☐ Does the student have any restrictions to physical education, sports, or activity? _____
☐ ☐ Does the student have any dietary restricts or a special diet? _____
☐ ☐ Diabetes – **Diabetic IHP must be completed. Last HbA1c percentage and date** _____
☐ ☐ Hypertension (high blood pressure) _____ **LIST MEDICATIONS**
☐ ☐ Heart disease _____ **LIST MEDICATIONS**
☐ ☐ Psychiatric/psychological or emotional difficulties. _____ **LIST MEDICATIONS**
☐ ☐ Behavioral/neurological disorder. _____ **LIST MEDICATIONS**
☐ ☐ Epilepsy or seizures – **Seizure type and date of last seizure:** _____ **LIST MEDICATIONS**
☐ ☐ Syncope/fainting _____ **LIST MEDICATIONS**
☐ ☐ Migraine headaches _____ **LIST MEDICATIONS**
☐ ☐ History of head injury/concussion. Date of injury_____. List any current restrictions _____
☐ ☐ Muscular/skeletal condition/muscle or bone issues _____
☐ ☐ Scoliosis _____
☐ ☐ Ear or hearing difficulty _____
☐ ☐ Eye or vision difficulty _____
☐ ☐ Bleeding disorder _____
☐ ☐ Kidney disease _____
☐ ☐ Thyroid disease _____
☐ ☐ Lung/respiratory disease _____
☐ ☐ Asthma – **Asthma Individual Health Plan must be completed**

Name of inhalers	Dosage	Time to be administered/PRN	Duration
			Entire time at AHS
			Entire time at AHS

☐ ☐ **May student self-administer and keep the inhaler under their control (backpack, purse or pockets)?**

ALLERGIES (Use the back if more space is needed):

YES NO
☐ ☐ Medication – Allergy List _____
☐ ☐ Insect bites/stings – Allergy List _____
☐ ☐ Food – List foods to avoid _____List foods to be substituted in lunch program _____
☐ ☐ Latex – Type of reaction _____
☐ ☐ **Does the student require the use of an Epinephrine Auto Injector at school?**
Allergy Individual Health Plan must be completed if an Epinephrine Auto Injector is ordered!

Name of medication	Dosage	Time to be administered/PRN	Duration
Epinephrine auto injector	0.3mg	PRN allergic reaction	Entire time at AHS

☐ ☐ **May student self-administer and keep the EPI-Pen under their control (backpack, purse or pockets)?**

PRESCRIPTION MEDICATION ORDERS (Medications to be administered at school):

Name of Prescription	Dosage	Time to be administered/PRN	Duration

If emergency treatment is required and parents and emergency contacts cannot be reached, the school authorities may use their judgment arranging medical care.
I hereby authorize the nurse, principal or other school personnel to call the physician named on this form or his/her associates if an emergency exist. This does not include release of information. I hereby authorize release of information to all Arrowhead High School personnel and school bus drivers.

Clinic Stamp

_____ _____ _____ _____
Parent Signature Date Physician signature Date