

A new form is required each year for students in Preschool, Kindergarten, grades 1, 3, 5, 7, 9, 11 and for **all** new students. Review and complete with your physician. Please note that **this form is not valid without a physician's signature.**

Form must be received by the Friday prior to the start of school

General

Student's Name (grade): _____ Birth Date: _____
 Physician's Name: _____ Contact Information: _____
 Date of Examination: _____
 Height: _____ Eyes: Right 20 / _____ Hearing: Right: _____
 Weight: _____ Left 20 / _____ Left: _____
 Blood Pressure: _____

Health History

- | | | | |
|--|-----|----|----------------|
| 1. Any adverse reactions to medication? | Yes | No | _____ |
| 2. Does the student have any allergies? | Yes | No | _____ |
| 3. Any food or dietary restrictions? | Yes | No | _____ |
| 4. Has the student ever been stung by a bee?
(If yes, please describe the allergic reaction) | Yes | No | _____
_____ |
| 5. Any respiratory problems or asthma? | Yes | No | _____ |
| 6. Any heart defects or heart disease? | Yes | No | _____ |
| 7. Any history of seizures, convulsions, epilepsy,
or other medical conditions? | Yes | No | _____
_____ |
| 8. Any ankle/hip/knee or other joint problems? | Yes | No | _____ |
| 9. Does the student have diabetes? | Yes | No | _____ |
| 10. If female, has the student menstruated?
(If not, does she know about it?) | Yes | No | _____
_____ |
| 11. Has the student consulted a mental health
professional in the past two years? | Yes | No | _____
_____ |
| 12. Does the student have any other medical
conditions that would preclude strenuous
activity? | Yes | No | _____
_____ |
| 13. Does the student wear glasses or contacts? | Yes | No | _____ |
| 14. Has the student had an appendectomy? | Yes | No | _____ |
| 15. Has the student had chicken pox? | Yes | No | _____ |
- (over)*

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Significant Medical History / Pre-existing Conditions

Please list the student's medical history including hernias, ulcers, head injuries, cancer, arthritis, scoliosis, hearing/vision problems, eating disorders, or other illnesses. Attach extra sheets if necessary. In addition, please note if the student has any pre-existing medical conditions. If pre-existing medical conditions may be affected by participation in daily activities at Riverstone, or on school trips, please document these conditions and discuss them with the school Outdoor Program Director.

Year	Illness/Incident/Condition	Implication(s)

Medications

Please indicate which medications prescribed for this child may be given during school hours.

Medication: _____ Dosage: _____ Frequency: _____ Reason: Special instructions or side effects:
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Conclusion & Immunizations

This student is in satisfactory condition and may engage in all usual school activities.

Immunizations: The State of Idaho requires that Riverstone keep an official documented record of immunizations on file for every student.

Attach a copy of the child's immunization record or complete an exemption form, which is available in the school office.

Signature of Examining Physician (required) Date

Signature of Parent/Guardian 1 (required) Date

Signature of Parent/Guardian 2 (required) Date