<table>
<tr><td colspan="6">Part 1: Demographics (Completed by Parent/Guardian)</td></tr>
<tr><td colspan="6">Student Name (First, Middle, Last):</td></tr>
<tr><td colspan="6">Parent/Guardian (First, Middle, Last):</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td><td colspan="4">Email Address:</td></tr>
<tr><td colspan="2">Street Address:</td><td>City:</td><td>State:</td><td colspan="2">Zip:</td></tr>
<tr><td colspan="2">Primary Care Provider:</td><td>Phone:</td><td colspan="3">Fax:</td></tr>
<tr><td colspan="2">Street Address:</td><td>City:</td><td>State:</td><td colspan="2">Zip:</td></tr>
<tr><td colspan="2">Dental Provider:</td><td>Phone:</td><td colspan="3">Fax:</td></tr>
<tr><td colspan="2">Street Address:</td><td>City:</td><td>State:</td><td colspan="2">Zip:</td></tr>
<tr><td colspan="2">Health Insurance Company Name:</td><td>Policy Number:</td><td colspan="3">Name of Primary Policy Holder:</td></tr>
<tr><td colspan="6">Part 2: Health History (Completed by Parent/Guardian)</td></tr>
<tr><td colspan="6">Does your child have any of the problems listed below?</td></tr>
<tr><td colspan="5">Allergies or Reactions (for example, food, medication or other)</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="6">If yes, please list:</td></tr>
<tr><td colspan="5">Hay Fever, Asthma, or Wheezing</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Eczema or Frequent Skin Rashes</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Convulsions/Seizures</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Heart Trouble</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Diabetes</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Frequent Colds, Sore Throats, Earaches (4 or more per year)</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Trouble with Passing Urine or Bowel Movements</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Shortness of Breath</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="5">Speech Problems</td><td>☐ Yes ☐ No ☐ Resolved</td></tr>
<tr><td colspan="6">Other (please describe):</td></tr>
<tr><td colspan="5">Does your child take medication(s) regularly?</td><td>☐ Yes ☐ No</td></tr>
<tr><td colspan="6">If Yes, list Medication and Reason:</td></tr>
<tr><td colspan="2">Does your child have Dental problems?</td><td colspan="2">☐ Yes ☐ No ☐ Resolved</td><td colspan="2">Date of last Dental Exam:</td></tr>
<tr><td colspan="6">If yes, please describe:</td></tr>
<tr><td colspan="5">Parent/Guardian Signature:</td><td>Date:</td></tr>
</table>

Pokégnek Bodéwadmik
POKAGON BAND OF POTAWATOMI
ZAGBËGON ACADEMY

<table>
<tr><td colspan="5">Part 3: Physical Examination and Immunizations (Completed by Healthcare Provider)</td></tr>
<tr><td colspan="5">Date of last physical examination:</td></tr>
<tr><td colspan="5">Was the child tested for?</td></tr>
<tr><td>Vision</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Hearing</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Urinalysis</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Blood Lead Level</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Hemoglobin/Hematocrit</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Tuberculin</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Blood Pressure</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td>Height and Weight</td><td colspan="2">◻ Yes ◻ No ◻ NA</td><td>Date:</td><td>Results: ◻ Normal ◻ Referred ◻ Under Care</td></tr>
<tr><td colspan="2">Are there physical exam findings that the school should be aware of?
◻ Yes ◻ No</td><td colspan="3">If yes, explain:</td></tr>
<tr><td colspan="2">Is there any vision, hearing, or other condition for which the school could help by seating or other actions?
◻ Yes ◻ No</td><td colspan="3">If yes, explain:</td></tr>
<tr><td colspan="2">Should the child's activity be restricted because of any physical defect or illness?
◻ Yes ◻ No</td><td colspan="3">If yes, explain:</td></tr>
<tr><td colspan="2">Is the child up to date on all childhood immunizations based on the schedule laid out by the CDC?
◻ Yes ◻ No</td><td colspan="3">If no, please list immunizations that are overdue:</td></tr>
<tr><td colspan="5">Other recommendations?</td></tr>
<tr><td colspan="4">Healthcare Provider's Name:</td><td>Degree or License:</td></tr>
<tr><td colspan="4">Healthcare Provider's Signature:</td><td>Date:</td></tr>
</table>