Lawrence County Health Department - Rural Health Clinic
2101 James Street, Lawrenceville, IL 62439 (618) 943-3302

SCHOOL / SPORT PHYSICAL CONSENT

*All forms must be filled out completely, please print clearly! This Patient Registration form is only good for **1 Calendar Year** from Today's Date.*

Today's Date: ____________________ Patient's Date of Birth: ____________________

Last: ______________________________ First: ____________________ Middle Initial: ________

Prefer to go by: ______________________________ Birth / Maiden Name: ______________________________

Birth Sex: Male Female Social Security Number: ______________________________

Marital Status: Single Separated Married Divorced Widowed

Race: American Indian Asian African American White Other: ____________________

Ethnic Group: Hispanic Non-Hispanic Preferred Language: ____________________

Address: ____

City: ______________________________ State: ____________________ Zip Code: ____________

Home Phone: ____-____-______ Cell Phone: ____-____-______

Email Address: ____ Preferred Contact Method: Phone Text

Responsible Party: Self Parent Spouse

Name: ____ Relationship to Patient: ____________________

Date of Birth: ____________________ Social Security Number: ______________________________

Phone: _____-_____-______ Employer: ____

Address: ____

Emergency Contact Information:

Name: ____ Phone Number: _______-________-__________

Name: ____ Phone Number: _______-________-__________

Insurance Information:

Primary Insurance Company: ____

Identification Number: ______________________________ Group ID: ______________________________

Policy Holder: ____ Relationship to Patient: ____________________

Date of Birth: ______________________________ Social Security Number: ______________________________

Phone Number: ____-____-______ Employer: ____

Address (if different from patient): ____

I authorize the personnel at the Lawrence County Health Department - Rural Health Clinic to conduct a school / athletic physical examination to the minor indicated above. I have received the HIPAA Privacy Practice Notice from the Lawrence County Health Department. I authorize the release of any information, including the diagnosis and the records of any treatment or examination, rendered to my child or myself during the period of such care, to the third-party payers and/or health practitioners.

____ ____________________

Parent / Guardian Signature Date

Revised: 02/21/2024

State of Illinois

Certificate of Child Health Examination

Student's Name			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle				
Street Address	City	ZIP Code	Parent/Guardian			Telephone (home/work)

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	**List:**	**MEDICATION** (Prescribed or taken on a regular basis)	☐ Yes ☐ No	**List:**

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No				
Developmental delay?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No				
Diabetes?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Seizures? What are they like?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Dizziness or chest pain with exercise?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Eye/Vision problems? ______ ☐ Glasses ☐ Contacts Last exam by eye doctor ______			☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other		
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) ______			Additional Information:		
Ear/Hearing problems?	☐ Yes ☐ No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No		Parent/Guardian Signatures: ______ Date: ______		

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				**Comments:** * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature ______________________ Title ______________________ Date ______________