

Special School District Health Services
Physical Examination

Student's Name: _____ DOB: _____

Parent/Guardian Name: _____ # _____

Parent/Guardian Name: _____ # _____

Home Address: _____

Home School District: _____

Special School District: _____

Dear Parent/Guardian:

The Special School District requests a complete physical exam on every child at the time of his/her enrollment. We ask that you have your child's physician complete this form and return it to his/her school nurse as soon as possible.

Childhood growth and development should be monitored by a physician at least every two years or at intervals determined by your child's physician. When your child is examined by his/her physician- please submit to the school nurse any changes in his/her condition or medications.

Thank you.

I give permission to the school nurse(s) to speak with my child's health care provider(s) in order to clarify the information in this report.

Parent/Guardian Signature _____

Date: _____

INSTRUCTIONS FOR PHYSICIANS

PHYSICAL EXAMINATION

This child attends a Special School District school. It is important that we are aware of any medical or mental conditions and/or changes. This information will be vital in planning an educational and/or health care plan. Your input is appreciated. Thank you.

Student Name: _____
 DOB: _____

HISTORY OF ILLNESS

DATE		
	Accidents (types)	
	Allergies (types)	
	Congenital Defects	
	Chicken Pox	
Seizures (type)		

RECORD OF IMMUNIZATIONS *Required by state law for attendance

	Date	Date	Date	Boosters
DPT/DTaP*				
DT*				
Td*				
OPV*				
IPV*				
MMR*				
HIB - ECE*				
HEP A				
HEP B*				
VARIVAX*				
MCV4*				

Restrictions/Accommodations/AdditionalComments. Complete below or attach additional page(s) if necessary.

Date _____ Height _____ Weight _____

Vision acuity _____ Conjunctivae _____

OD _____ OS _____ OU _____ Pupils _____

Hearing acuity _____ TMs _____

Nose _____ Throat _____

Mouth/teeth _____ Lymph nodes _____

Thyroid _____ Spine _____

Heart _____ Rate/Rhythm _____

Lungs _____ BP _____

Abdomen _____ Hernia _____

Genitalia _____ Extremities _____

Skin _____ CNS _____

Diagnosis _____

Current Medications and dosages _____

Physician Name and Signature: _____