Minnesota State Academies – PHYSICIAN'S EVALUATION REPORT

NOTE: Medical Doctor must complete this page.

Student name	**Birthdate**	**Weight**	**Height**	**BMI**
Diagnosis		**ICD-10-CM**		

Does student have any known allergies? YES NO If yes, list and describe allergic response and treatment:

_____

Is there a history of seizures? YES NO If yes, describe type, level of control:

_____

Is student on medication (seasonal, continuous)? YES NO If yes, list and attach prescription. Students must have a Physician order for all medications, including over-the-counter medications.

DRUG	**DOSE**	**ROUTE**	**TIME**	**PURPOSE**	**POSSIBLE SIDE EFECTS**

_____

_____

_____

Does student have any dietary restrictions or require a special diet? YES NO If yes, describe**:**

_____

Does student have a physical condition which limits his/her participation in classroom activity, physical education, or competitive sports? NO YES (If yes, describe):

_____

Are there any recommendations for further evaluation? (diagnostic procedures, re-evaluation, physical therapy etc):

_____

If the student has an involved medical problem (e.g. diabetes), please supply detailed guidelines for management of condition under the supervision of the school health staff.

PHYSICAL EXAMINATION RESULTS

Blood Pressure:_____ Pulse:_____ Resp.:_____ Lab Results:_____

Physical Findings and comments:

Immunizations Given Today: _____

PHYSICIAN'S VERIFICATION OF INFORMATION

Physician Name Printed:_____ Physician's Signature:_____

Address:_____

Telephone Number:_____ Date of Examination: _____