HEALTH EXAMINATION FORM

St. Croix
LUTHERAN
ACADEMY

1200 Oakdale Ave
West St. Paul, MN 55118
(651) 455-1521

Name: _____ _____ _____
           (Last/Surname)   (First/Given)   (Middle)

Date of Birth: ____/____/____ **Gender**: ❑ Male ❑ Female **Grade**: _____

Required for SPORTS:

I certify that the above-named student has been medically evaluated **with the following recommendations:**

❑ **YES -** The student is cleared for all sports and activities without restriction.
❑ **NO -** The student is not cleared for sports.
❑ The student is cleared for sports with the following restrictions:_____

	Normal	Abnormal
Eyes		
Ears		
Mouth – Dental		
Throat		
Nose		
Lymph Nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Hernia	❑ No	❑ Yes
Genito-Urinary		
Tanner Staging (circle one) I II III IV V		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Behavior		

Height: _____(ft)____(in) **Weight:** _____(lbs)
Blood Pressure: _____/_____ **Heart Rate:** _____
Vision: R 20/_____ L 20/_____ **Correction:** ❑ Y ❑ N
Hearing: ❑ Normal ❑ Abnormal **Hearing Aids:** ❑ Y ❑ N

	500 (25)dB	1000 (20)dB	2000 (20)dB	4000 (20)dB
R				
L				

Allergies: _____
_____

There is a condition that may result in an emergency:
❑ Yes ❑ No   If yes, explain below.

There is a condition that may interfere with learning:
❑ Yes ❑ No   If yes, explain below.

Females:
Age at first menstrual period? _____
How many periods in the past 12 months? _____

Describe any abnormal findings or chronic conditions or attach documentation.

Health Concerns	Medications/Treatment/Referral Plan	Recommendations for School

Note: A separate form is required for all medications and treatments to be administered at school.

_____
Signature and title of health care provider

_____
Print Name

_____
Date of Physical Exam

_____
Clinic Name

_____
Phone

_____
Fax

_____
Clinic Address

_____
Email