

WISCONSIN DELLS SCHOOL DISTRICT

Spring Hill School
300 Vine Street
Wisconsin Dells, WI 53965
(608) 253-2468
Fax 254-6397

Neenah Creek School
PO Box 68
Briggsville, WI 53920
(608) 981-2341
Fax 981-2104

Lake Delton Elementary
PO Box 280
Lake Delton, WI 53940
(608) 253-4391
Fax 254-6765

Physical Examination (4K & 5K)

Student's Name _____ Birth Date _____

PARENT: We urge you to take your child to the doctor before school begins for an examination and any recommended care. When the examination is completed, **please return this form to the school.**

IMMUNIZATION HISTORY (EXACT DATES REQUIRED-(INCLUDE ANY DOSES GIVEN TODAY))					
	1 st	2 nd	3 rd	4 th	5 th
DTP/DT/DTaP/Td	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
HEPATITIS B	_____	_____	_____	_____	_____
MMR	_____	_____	VARICELLA	_____	_____
OTHER	_____	_____	_____	_____	_____

HT _____ WT _____
BP _____ OTHER _____
Results of vision screening if done _____
Results of hearing screening if done _____

GENERAL APPEARANCE _____
SKIN _____ EYES _____ EARS _____ NOSE _____
MOUTH _____ THROAT _____ TEETH _____
RESPIRATORY _____
CARDIOVASCULAR _____
GASTROINTESTINAL _____
GENITOURINARY _____
MUSCULAR / SKELETAL _____
NEUROLOGICAL _____

- Are any allergies (bee sting, food allergy, etc.) LIFE THREATENING? No Yes, please describe.
Does student need emergency epinephrine available? No Yes
- Does this child have a health concern that may require special attention while he or she is at school: (e.g. seizure disorder, diabetes, heart problem, severe asthma, bleeding problem,). No Yes If yes, please describe.
- Is this student on medication? No Yes If yes, please list medication, dosage and frequency.
***A medication order form must be completed for school staff to administer medication at school.*
- Are there any restrictions of physical activity or physical education in school? No Yes, describe nature, duration, any special equipment
- Does student need special nutritional consideration? No Yes, describe.
- Are there other findings on exam, family or health history or review of systems that may impact this child's health or learning during school? _____

Examiner signature _____ Exam date _____

Printed name of examiner _____

Address & phone of examiner _____

Please return this form to the School (address listed above). Thank you.