ST. CLOUD AREA SCHOOL DISTRICT 742 ANNUAL PHYSICAL FORM

If you child needs a sports physical, please use the Minnesota State High School League document or have your healthcare provider print the clinic's sports physical document. Return sports physicals to the school nurse.

Name _____ Male _____ Female _____ Birthdate _____
Address _____ Phone _____
Parent/Guardian _____
Physician/Healthcare Provider _____ Dentist _____
Last physical exam _____ Last dental exam _____

Significant Past History

YEAR		YEAR
Allergy (specify)		Mental Health Condition (specify)
Asthma		Neurologic (specify)
Chicken Pox (Disease)		Orthopedic (specify)
Congenital Defect (specify)		Seizure History
Developmental Delay		Surgeries (specify) T&A Myringotomy tubes, Hernia
Diabetes		Vision: Glasses or Contacts
Hearing		Other
Heart Condition		

Health Examination

(To be completed by Physician/Healthcare Provider)

Examining Physician's/Healthcare Provider's Name (Print) _____
Ht. _____ Wt. _____ BMI _____ Pulse _____ BP _____ Urinalysis _____ HGB _____

Eyes _____
Ears _____
Nose _____
Throat _____
Glands _____
Lungs _____
Heart _____
Nervous System _____

Orthopedic/Scoliosis _____
Skin _____
Allergies (if so, what?) _____
_____
Nutrition _____
Serious Illnesses _____

Please review immunizations and update for school requirements as needed. Please attach copy of immunization record.

Does student require medication on a daily or episodic routine?
Name of medication: _____
Dose: _____ Frequency: _____
Condition being treated: _____
****Please include a separate physician/healthcare provider's order if medication will be taken at school.***

Significant Development History _____
History of: Hearing Problem _____ Speech Problem _____
History of: Social or Emotional Problem _____
List conditions which may limit participation in:

A. Classroom Activity _____
B. Physical Education _____
C. Competitive Sports _____

***If child is participating in sports, please complete MSHL sports physical form or provide clinic generated document.
Any special health problems, recommendations and/or comments _____
Immunization(s) given today _____
Approved for: Full Activity _____ Limited Activity _____
Date _____ Examining Physician/Healthcare Provider Signature _____

I hereby release this information to the Health Services Department of District 742 and give the licensed school nurse permission to clarify the information with the Physician/Healthcare Provider if the need arises.

_____
PARENT/GUARDIAN SIGNATURE