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

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.

PHYSICAL EXAMINATION

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 ____________________________

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Physician Name and Signature:___________________________________

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