

ST. CLOUD AREA SCHOOL DISTRICT 742 PHYSICAL FORM

This form is confidential.

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)	ADHD ADD
Asthma	Developmental Delay
Chicken Pox (Disease)	Seizure History
Congenital Defect (specify)	Vision Glasses _____ Yes
Diabetes	Hearing
Heart Condition	Surgeries (specify)
Neurologic (specify)	T & A
Orthopedic (specify)	Myringotomy Tubes, Hernia
	Other

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 _____ Orthopedic/Scoliosis _____
 Nose _____ Skin _____
 Throat _____ Allergies (if so, what?) _____
 Glands _____
 Lungs _____ Nutrition _____
 Heart _____ Serious Illnesses _____
 Nervous System _____

Please review/record immunizations on reverse side and update for school requirements as needed.

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 _____

Any special health problems, recommendations and/or comments _____

Immunization(s) given today _____

Approved for: Full Activity _____ **Limited Activity** _____

Date _____ **Examining Physician/Healthcare Provider** _____

I hereby release this information to the Health Service 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