STUDENT HEALTH ASSESSMENT/PHYSICAL EXAMINATION FORM

To be completed by a Licensed Physician

Name ______________________ Age ________ Sex ________ Grade ______

Height ____________ Weight ____________ Blood Pressure ________________ Blood Type ______

1. Does this child have a health condition which may require **EMERGENCY ACTION** while he/she is at school? (e.g., seizure, insect sting, asthma, allergy, bleeding problem, diabetes, heart problem?) If yes, please DESCRIBE.
   ❑ No ❑ Yes ______________________

2. Is the student on long-term medication? If yes, please DESCRIBE.
   ❑ No ❑ Yes ______________________

   (A Medication Administration Form must be completed for in-school administration).

3. Is there evidence for concern for any of the areas listed below? Indicate the results of your examination by checking the appropriate space.

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision…………………………				Adjustment…………….			
Hearing………………………				Nutrition…………………			
Speech/Language……….				Immunodeficiency…..			
Development………………				Lead Poisoning……….			
Attention Deficit/ Hyperactivity………………				Physical Illness/ Impairment…………….			
Scoliosis………………………				Other………………………			

REMARKS: (Please explain any "yes;" include recommendation for referral and treatment.)

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4. Should there be any restriction of physical activity in the school? If so, specify nature and duration of restriction.
   ❑ No ❑ Yes ______________________

(Student Name) ______________________ has had a complete physical examination and has

❑ no evident problem that may affect learning ***OR*** ❑ problems noted above

PROVIDER INFORMATION

Physician's Printed Name	Signature and Title	License Number	Date

Address	Office Phone Number