Texto en lengua española en el otro lado

HEALTH CARE PROVIDER REPORT OF STUDENT'S PHYSICAL EXAMINATION

School District of Reedsburg

Student: _____ M F Birthdate: _____ School: _____

Parent: _____ Phone: _____

Complete Address: _____

To be completed by parent/guardian before physical exam given.

	YES	NO
1. Does your child have a health concern which may require an Individual Health Care Plan while he or she is at school (e.g. seizure disorder, diabetes, heart problem, severe asthma, bleeding problem, bee sting or severe food allergy, reaction to latex)? If yes, please describe.	☐	☐
2. Are there any allergies to foods, environmental, latex or medication? If yes, list specific reactions.	☐	☐
3. Are any allergies LIFE-THREATENING? If yes, please describe.	☐	☐
4. Is an **EPI-PEN** required? **	☐	☐
5. Are medications taken daily? If yes, please list medication, dosage and frequency, and if need to be taken at school. **	☐	☐
6. Are there any restrictions of physical activity or physical education in school? If yes, please describe nature, duration and any special equipment used.	☐	☐
7. Are there special nutritional considerations? If yes, please describe.	☐	☐
8. Are there any other significant health history concerns that may impact your child's health or learning during the school year? (i.e. ADHD, glasses, etc.)	☐	☐

**** A medication request/consent form must be completed for school staff to administer medication at school.**

3/11 Please return to: School Nurse, 501 K Street, Reedsburg, WI 53959

This portion is to be completed by the medical provider.

SCREENING:

Height (in inches) _____

Weight (in pounds) _____

Blood Pressure _____

Results of vision screening (if done) _____

Results of hearing screening (if done) _____

PHYSICAL EXAM:	NORMAL	ABNORMAL (describe)
Appearance:		
Skin		
Eyes, ears, nose, throat		
Lymph nodes		
Neck, thyroid		
Heart/pulses		
Lungs		
Abdomen (include hernia)		
Genitourinary		
Gastrointestinal		
Neurological		
Psychological		
Musculoskeletal		

Is the student under treatment for any medical or mental health conditions? ☐ No ☐ Yes If yes, please specify _____

_____

ASSESSMENT/PLAN:

1. General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Immunizations given or updated: _____

3. Are there any physical activity restrictions? ☐ No ☐ Yes If, yes, please specify _____

_____

4. Medications during school day? ☐ No ☐ Yes ** _____

_____

5. Examiner's comments/other recommendations: _____

_____

Signature/Title of Health Examiner: _____ **Date:** _____

Printed or Typed Name of Examiner: _____

Address of Examiner: _____ **Phone Number:** _____

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