SCHOOL DISTRICT OF REEDSBURG

HEALTH CARE PROVIDER PHYSICAL EXAMINATION

Student:_____

Birthdate:_____ School:_____

Parent or Guardian:_____Phone:_____

To be completed by health care provider.

SCREENING

Height:_____ Weight:_____ Blood Pressure:_____

Vision Screening Results:_____ Hearing Screening Results:_____

PHYSICAL EXAM	**Normal**	**Abnormal - Describe**
Skin		
Eyes, ears, nose, throat		
Neck, lymph nodes, thyroid		
Neurological		
Heart/Pulses		
Lungs		
Abdomen		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Psychological		

Is the student under treatment for any medical or mental health condition? Yes ☐ No ☐

If yes, please specify._____

ASSESSMENT/PLAN

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Immunizations given:_____

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

Medications during the school day? Yes ☐ No ☐ If yes, please specify._____

Healthcare Provider's comments or recommendations:_____

_____

Name/Title of Examiner:_____ Phone:_____

Signature of Examiner:_____ Date:_____

Please return to School Nurse.