SCHOOL DISTRICT OF REEDSBURG

PHYSICAL EXAMINATION

Student:_____

Birthdate:_____ School:_____

Parent or Guardian:_____Phone:_____

To be completed by <u>parent or guardian</u> before physical exam.

1. Does your child have a health concern which may require an Individual Health Plan while he or she is at school (seizure disorder, diabetes, heart problem, severe asthma, bleeding problem, bee sting or severe food allergy, reaction to latex)?
Yes ☐ **No** ☐ If yes, please describe.

2. Are there any allergies to foods, bee stings, or latex? Are any life threatening?
Yes ☐ **No** ☐ If yes, please describe.
Is an EpiPen required? *****
Yes ☐ **No** ☐

3. Are medications taken daily?
Yes ☐ **No** ☐ If yes, please list medication, dosage, frequency, and if need to be taken at school. *

4. Are there any restrictions on physical activity or physical education in school?
Yes ☐ **No** ☐ If yes, please describe nature, duration and any special equipment used.

5. Are there special nutritional considerations?
Yes ☐ **No** ☐ If yes, please describe.

6. Are there any other health history concerns that may impact your child's health or learning?
Yes ☐ **No** ☐ If yes, please describe.

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

Please return to School Nurse.