****Please mail form directly to the school your child is attending by August 15.**

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) T & A Myringotomy Tubes, Hernia	
Neurologic (specify)		
Orthopedic (specify)	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_____
Nose_____
Throat_____
Glands_____
Lungs_____
Heart_____
Nervous System_____
Orthopedic/Scoliosis_____
Skin_____
Allergies (if so, what?)_____
_____
Nutrition_____
Serious Illnesses_____

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