BELOIT UNIFIED SCHOOL DISTRICT NO. 273

STUDENT HEALTH ASSESSMENT

Student's Full Name _____ Grade _____ Sex _____
Address _____
Name of Parents _____

TO BE FILLED OUT BY PHYSICIAN OR QUALIFIED PROVIDER

IMMUNIZATIONS: Are immunizations up to date? _____ Needs _____
PHYSICAL EXAMINATION: Height _____ Weight _____ Blood Pressure _____

PHYSICIANS COMMENTS, FINDINGS, TESTS

Skin Scalp _____ Eyes _____
Ears _____ Nose, Throat _____
Mouth, Teeth, Gums _____
Speech _____ Glands, Thyroid _____
Heart _____ Lungs _____
Abdomen _____ Genitalia _____
Neurologic _____ Extremities _____
Spine (Scoliosis) _____ Nutrition _____
LABORATORY (IF DONE): Hgb or Hct _____ Urine _____ Blood Lead _____

HEALTH HISTORY

Is this student subject to any conditions which could make for a classroom emergency, such as convulsive disorder, fainting, diabetes, allergies or asthma? _____
_____
_____

Are there any emotional, behavioral or growth and development problems with which the teachers should be acquainted? _____
_____

_____

Any past injuries or operations? _____
Significant family history (Scoliosis, diabetes, tuberculosis, visual defect, hearing loss, etc) _____
_____
_____

Is this student receiving continuous medication or therapy (If so, please elaborate) _____
_____

_____

Significant findings and physician's recommendations to parents and teachers: _____
_____
_____

RECOMMENDATIONS FOR PHYSCIAL EDUCATION

FULL PROGRAM _____
RESTRICTED (Explain) _____
NO PARTICIPATION (Explain) _____

Date of Examination _____ Signature _____ M.D. _____ or Health Provider _____