



**BELDIT 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 PHYSICAL EDUCATION**

FULL PROGRAM \_\_\_\_\_  
RESTRICTED (Explain) \_\_\_\_\_  
NO PARTICIPATION (Explain) \_\_\_\_\_

Date of Examination \_\_\_\_\_ Signature \_\_\_\_\_ M.D. \_\_\_\_\_ or Health Provider \_\_\_\_\_