

BURLINGTON AREA SCHOOL DISTRICT PHYSICAL EXAMINATION

Last Name _____ First Name _____ Middle Initial _____

School _____ Date of Birth _____ Grade _____

Parent/Guardian _____ Address _____

<u>PAST HEALTH HISTORY</u>	<u>Year</u>	<u>IMMUNIZATIONS</u>	<u>MO/DAY/YR</u>
Rheumatic Fever	_____	DTaP/DTP/DT/Td	_____
Heart Problems	_____		_____
Epilepsy	_____	Polio	_____
Convulsions/Seizures	_____		_____
Diabetes	_____	Td Boosters	_____
Cerebral Palsy	_____	Measles, Mumps, Rubella	_____
Kidney Disease	_____	HepB	_____
Allergies	_____	Chicken Pox (Varicella)	_____
Asthma	_____		
Other	_____		
Operations	_____		

CLINICAL FINDINGS

*BLOOD WORK: HBG _____ HCT _____ WBC _____

*URINALYSIS: Albumin _____ Sugar _____

Height _____ Vision R _____ L _____

Weight _____ Hearing R _____ L _____

Summary of significant findings: _____

Referred to specialist: _____

SCHOOL

May attend school with Unlimited Activity _____

May attend school with Limited Activity (please describe) _____

Requires Homebound Instruction _____

Any Physical Limitation (please describe) _____

Other _____

Recommendations for follow-up by school nurse: _____

Date of Exam _____ Physician's Name (printed or typed) _____

Address & Phone Number _____

Physician's Signature _____

***If available**