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School District of Black River Falls
301 North Fourth Street
Black River Falls, WI 54615
(715) 284-1618 Ext. 1206

PHYSICAL EXAMINATION/ HEALTH HISTORY FORM

STUDENT NAME: ____________________________ **BIRTHDATE:**____________ **GRADE:** _________

MOTHER'S NAME:____________________________ **PHONE:**________________________________

FATHER'S NAME:___________________________ **PHONE:**_______________________________

HEALTH HISTORY **(parents complete what you know for the physician, prior to the appointment) - Please attach copy of immunization record**

Allergies:____

Asthma:____

Non-Insulin Dep. Diabetes____

Insulin Dependent Diabetes ____

Epilepsy/Seizure Disorder:____

MRSA____

Kidney Infection/Renal Problems:____

Cardiac Problems:____

Cancer:____

Surgeries:____

Other:____

Medications:_______________________________ _____at home _____at school (complete med administration form)

_______________________________ _____at home _____ at school (complete med administration form)

_______________________________ _____at home _____ at school (complete med administration form)

Physical **(all to be completed by the physician/NP/Pa-C) –please help family complete the health history section also. Thank you**

VITAL SIGNS/ LABS

Blood Pressure: ________ Pulse______ Resp______ Temp:_____ Height: __________

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Weight_____________ Hematrocit: _________________ Urinalysis:_______________

EXPLAIN **"ABNORMAL"** FINDINGS in vital signs and/or labs:

PHYSICAL Only need to CHECK **"ABNORMAL"** FINDINGS :

____ Head	____ Chest	____ Coordination
____ Eyes	____ Lungs	____ Back
____ Ear	____ Heart	____ Extremeties
____ Nose	____ Abdomen	____ Skin
____ Throat	____ Genitalia	____ Metabolic
____ Neck	____ Muscle Tone	____ C.N.S.

EXPLAIN **"ABNORMAL"** FINDINGS from above:

CLASSIFICATION FOR PHYSICAL EDUCATION ACTIVITY:

I. ____ Unlimited Activity
II. ____ Slight Modified – Under Observation
III. ____ Restricted
IV. ____ No Physical Education

EXPLAINATION OF ACTIVITY LEVEL OTHER THAN A IV AN ANY OTHER ADDITIONAL REMARKS AND RECOMMENDATIONS: (Include need for medical, dental, or psychological care)

DATE: ___________ **SIGNATURE OF EXAMINING PHYSICIAN:** ________________________________

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Physician's name printed **Phone number**