STUDENT HEALTH EXAMINATION **School District of Grafton**

TO BE COMPLETED BY PARENT/GUARDIAN

Student Last Name:	First Name:	Middle Initial:
Gender: ❑ Male ❑ Female	Date of Birth:	Grade:
Street Address:	City:	Zip:
Parent / Guardian Name:	Phone:	

MEDICAL HISTORY	YEAR
Physical disabilities	
Asthma	
Heart	
Seizures	
Allergies	
Chicken pox	
Pertussis (whooping cough)	
Serious injuries	
Surgeries	
Other	

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

PHYSICAL EXAMINATION **Date:**

	Normal	Abnormal	Findings
HEENT	❑	❑	_____
Neurological	❑	❑	_____
Dental/Oral	❑	❑	_____
Respiratory	❑	❑	_____
Cardiac	❑	❑	_____
Gastrointestinal	❑	❑	_____
Musculoskeletal	❑	❑	_____
Genitourinary	❑	❑	_____
Skin	❑	❑	_____

Allergies:

Medication

❑ Child takes medicine for specific health conditions:

List medication(s): 1._____ 3._____
2._____ 4._____

❑ Medication must be given and/or available at school

Physical education activity recommendation

❑ Full activity
❑ Full activity without competitive sports
❑ Full activity under close supervision
❑ Limited activity Specify:_____

_____ _____
Physician's Signature *Date*

_____ _____
Physician's Name *Address*