STUDENT HEALTH ASSESSMENT
FOR USD 379

Dear Parents:

A health appraisal from a health care provider is most important for every student's general welfare and for the school to have an understanding of individual needs. A physical exam is required by Kansas law for every pupil up to the age of nine years who has not previously enrolled in any school in this state prior to admission to and attendance in school. This assessment shall have been conducted within 12 months of school entry. To help the school do its best with your child, please return this form with any recommendations that may be necessary.

Name _____ D.O.B. _____ Grade _____ Sex _____

Address _____ Phone _____

Name of Parent/Gaurdian _____

TO BE FILLED OUT BY PHYSICIAN OR QUALIFIED PROVIDER

Height _____ Weight _____ Blood Pressure _____

Skin/Scalp _____ Eyes _____

Ears _____ Nose/Throat _____

Mouth/Teeth/Gums _____ Glands/Thyroid _____

Speech _____ Lungs _____

Heart _____ Genital-Urinary _____

Abdomen _____ Extremities _____

Neurologic _____ Nutrition _____

Orthopedic/Spine/Scoliosis _____ Allergy/Bee Sting _____

Laboratory (if done): Hgb or Hct _____ Urine _____ Blood Lead _____

1. Is there any defect of vision or hearing for which the school could help compensate by proper seating or other action? Yes ☐ No ☐

   If yes, what do you recommend? _____

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

   _____

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

   _____

   _____

4. Any past injuries or operations? _____

   _____

5. Significant family history (scoliosis, diabetes, tuberculosis, visual defects, hearing loss, etc…)

6. Is this student receiving continuous medication or therapy? (If so, please elaborate)

7. Significant findings and physician's recommendations:

Recommendations for Physical Education

Full program _____

Restricted (explain) _____

No participation (explain) _____

Health Care Provider Signature	Title	Date

Parent Signature