Waverly-Shell Rock Community School District
School Physical Form

To be completed by health care provider

Student's Name	Birthdate
Parent's Name	Phone
Physician's Name	Phone

	Date	Comments		Date	Comments
Food Allergies			Heart Disease		
Medicine Allergies			Meningitis		
Other Allergies			Mononucleosis		
Asthma			Seizures		
Cancer			Freq. Throat Infections		
Chicken Pox			Surgery		
Bleeding Problems			Injuries		
Diabetes			Hospitalizations		
Freq. Ear Infections			Other		

Date of Exam _____

Height	Weight (lb)	BP	Hemoglobin	Lead Screen	Vision (Right)	Vision (Left)	Corrective Lenses?	Hearing

	Normal (√)	Abnormal (√)	Comments
Skin			
Eyes			
Ears			
Nose			
Mouth/Dental			
Lymph Nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Musculoskeletal			
Endocrine			
Posture			
Nutritional Status			
General Appearance			
Developmental			
Other			

Medications
Activity Restrictions
Conditions that might affect school performance

Signature _____ **Date** _____

Please return the completed form to school.