BAUGO COMMUNITY SCHOOLS
Small School Feel—World Class Education

School: _____
Grade: _____ Date: _____

PHYSICAL EXAMINATION FORM

RETURN THIS COMPLETED FORM TO SCHOOL BY THE FIRST DAY OF ATTENDANCE

HEALTH INFORMATION: TO BE FILLED OUT BY PARENT/GUARDIAN

Student Name_____ Birthdate_____ **(month/day/year)**

Parent or Guardian_____ Phone_____

Medical History:

Does your child have any of the following:

Allergies (specify): _____

Seizures: _____

Diabetes: _____

Asthma: _____

Other: _____

Medications currently prescribed: _____

Has your child had any serious illnesses, accidents, or surgery that may have caused any impairment?

☐ **NO** ☐ **YES**

If yes, state reason: _____

PHYSICAL EXAMINATION: TO BE FILLED OUT BY PHYSICIAN

Height: _____ Weight: _____ Blood Pressure: _____ Heart Rate: _____

	Normal	Abnormal		Normal	Abnormal
Eyes (except vision)			Heart		
Ears (except hearing)			Lungs		
Nose			Abdomen		
Throat			Extremities		
Skin			Other		

Does student wear glasses? ☐ **NO** ☐ **YES**

Comments: _____

Is the child under medical treatment currently? ☐ **NO** ☐ **YES**

If yes, state reason: _____

PLEASE SEE OTHER SIDE

Please Check:

Sickle Cell Anemia: ☐ **NO** ☐ **YES** Date _____ Results _____ (must be reported if done).

Lead Poisoning: ☐ **NO** ☐ **YES** Date _____ Results _____ (must be reported if done).

Is the child physically fit to participate in a physical education program? ☐ **NO** ☐ **YES**

If no, state reason: _____

*In Indiana all students are **required** to pass two semesters of physical education to meet the graduation requirements. No school, school corporation, or physician may grant a waiver. If your student requires an alternative to the basic physical education program, a physician needs to complete the referral form, available at the high school.

The above Health Conditions and Examination have been reviewed by the parent and the physician:

Date of Office Examination: _____ Doctor Phone Number: _____

X_____ X_____

Physician Signature Parent or Guardian Signature

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DENTAL EXAMINATION: TO BE FILLED OUT BY DENTIST

I have examined the teeth of _____

Teeth_____

Para-oral Structure_____

Infection_____

Abnormalities_____

Is further treatment necessary? ☐ Immediate ☐ Routine Care ☐ No

Have further arrangements been made for further treatment? ☐ Yes ☐ No

Comments_____

Date of Examination_____ Office Phone_____ Dentist's Signature_____