

THE PRAIRIE SCHOOL
HEALTH/PHYSICIAN'S PHYSICAL FORM

Student Name _____ Date of Birth ___/___/___ Grade _____

Height _____ Weight _____ Blood Pressure _____

Please note any health problem, chronic health condition, or disability that might affect behavior or health at school: _____

Are there any medical conditions, past or present of significance to the school? (cardiovascular, diabetes, asthma, epilepsy, dietary restrictions) Yes _____ No _____

If yes, explain _____

Operations or serious injuries _____

Allergies (including food, drug and environmental) Yes _____ No _____

If yes, please list and explain _____

Epinephrine Auto-Injector required Yes _____ No _____

Is there any defect of vision, hearing, or speech for which the school could compensate by proper seating, medication, or other action? Yes _____ No _____

Medication/Seating _____

Is there any information regarding emotional stability of which the school should be aware? (Psychological diagnosis/therapy) Yes _____ No _____

If yes, please explain _____

Please check appropriate statement: _____ Unlimited physical education activity
_____ Limited physical education activity

Significant physical findings and recommendations _____

I CERTIFY THAT I HAVE EXAMINED THE ABOVE CHILD ON THIS DATE

Date _____

Physician's Signature _____

Phone _____

Print Name of Physician _____