



**ROCKWOOD SCHOOL DISTRICT PHYSICAL EXAMINATION FORM**  
**FOR**  
**KINDERGARTEN • NEW STUDENTS • GRADE 6 • HIGH SCHOOL SPORTS**

Please return completed health examination form to the school nurse.  
 Any questions regarding completion of this form may be directed to the school nurse.

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**TO BE COMPLETED BY EXAMINER**

**DATE OF EXAM:** \_\_\_\_\_

**IMMUNIZATIONS** (give month/day/year or attach record)

DTP \_\_\_\_\_  
 DTaP/Td \_\_\_\_\_ Hep B \_\_\_\_\_  
 Polio \_\_\_\_\_  
 MMR \_\_\_\_\_ Hep A \_\_\_\_\_  
 Varicella \_\_\_\_\_ or Date of Illness \_\_\_\_\_  
 HIB \_\_\_\_\_  
 PPD +/- \_\_\_\_\_ **Menactra** \_\_\_\_\_  
 Other \_\_\_\_\_

**HISTORY**

Asthma: No \_\_\_\_\_ Yes \_\_\_\_\_  
 ADHD: No \_\_\_\_\_ Yes \_\_\_\_\_  
 Chronic Condition/Major Surgeries: (list, give date) \_\_\_\_\_  
 \_\_\_\_\_  
 Allergies (list): \_\_\_\_\_  
 Medications (list): \_\_\_\_\_

**ORTHOPEDIC HISTORY** (for sports participation)

Previous Injury Date, Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Special Seating Recommendations:** \_\_\_\_\_

**Medical Treatment Needed at School:** \_\_\_\_\_

**Other Health Recommendations:** \_\_\_\_\_

**PHYSICAL**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_  
 Eyes: R – 20/ \_\_\_\_\_, L – 20/ \_\_\_\_\_ Hearing: \_\_\_\_\_  
**Review of Systems: WNL**  
 If not, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**ORTHOPEDIC EXAM** (for PE/sports participation)

**Back/Neck/Shoulders/Extremities: WNL**  
 If not, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**Recommendation for PE/Sports: Full / Limited / None**  
 Clearance withheld until: \_\_\_\_\_  
 If limitations, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**SIGNATURE of EXAMINER:** \_\_\_\_\_

Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_

**For High School Sports Participation Only - Parent's or Guardian's permission:** I hereby give my consent for the student to represent his/her school in interscholastic activities, except those stated on the form by the examiner; I also give my consent for him/her to accompany the team as a member of its out-of-town trips and will not hold the school responsible in case of accident or injury. I also give consent and authorize the school to obtain, through a physician of its choice, such medical care as is necessary for the welfare of the student, if he/she is injured in the course of school activities.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_



# ANNUAL STUDENT HEALTH INFORMATION

(to be completed by parent/guardian)

Student name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Please check any of the following conditions that affect your child:

- | Yes                      | No                       |                                       |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | ADHD                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (please specify)            |
|                          |                          | Food _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Epinephrine prescribed _____          |
|                          |                          | Medication _____                      |
|                          |                          | Animal _____                          |
|                          |                          | Environmental _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism/Aspergers Spectrum             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing concerns                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Bowels                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart/Lung                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney/Bladder                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision – contacts/glasses/other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other                                 |

Please give specifics for any of the above marked yes \_\_\_\_\_  
History of surgeries, major illness or injury \_\_\_\_\_

Is the student currently under any kind of on going medical treatment or care?  Yes  No  
Currently taking any medication on a regular basis (prescription or over the counter)?  Yes  No  
List name, dose, times and reason for taking. \_\_\_\_\_

Medical/Nursing care needed at school (describe in detail).

**Please note that health concerns such as diabetes, seizures, asthma, and severe allergic reactions will need additional health care plans. Please contact your school nurse as soon as possible to schedule an appointment to complete this information.**

Physician's name \_\_\_\_\_ phone# \_\_\_\_\_  
Dentist's name \_\_\_\_\_ phone# \_\_\_\_\_  
Specialist's name \_\_\_\_\_ phone# \_\_\_\_\_

**To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. I agree to alert the school nurse of any change in medication and/or health status of my child. I will furnish the school with a current telephone number and address in case of emergency.**

### EMERGENCY AUTHORIZATION:

I agree that in an emergency, any Rockwood representative may transport or authorize the transportation of my child to a hospital/medical facility and I authorize any physician or other medical personnel to carry out any diagnostic procedures or emergency care deemed necessary. I prefer my child be taken to \_\_\_\_\_ hospital. I understand that the cost of medical attention and ambulance are my responsibility. I acknowledge that the foregoing above information is true and correct.

Signature of parent (Legal Guardian if child is in custody of anyone other than parent) \_\_\_\_\_ Date \_\_\_\_\_