RSU No. 5 Durham - Freeport - Pownal
STUDENT PHYSICAL EXAM

For Students Entering Preschool K 3rd 6th 9th & all Transfer Students

To the Health Care Provider: Please Complete and Sign

(Physician, Osteopath, Nurse Practitioner, Certified Nurse-Midwife of Physician Assistant)

_____ _____ _____

Student's Name DOB GRADE

IMMUNIZATIONS

Please attach a complete Immunization Record. Is this student's record in *ImmPact*? ❑ Yes ❑ No

Student has a documented history of chickenpox disease? ❑ No ❑ Yes _____ Last Tetanus? _____

Date Date

Medical Exemption: This student has not received immunizations for medical reasons. (*Specify immunizations*)

_____

❑ Permanent ❑ Temporary (*Specify plan for immunization*) _____

_____

This student is on long-term medication ❑Yes ❑ No
Please specify:

Medication	Dose	Time	Frequency

B/P	Pulse	
HT	WT	BMI

This student has the knowledge and skill to carry and self-administer this medication. ❑ Yes ❑ No

HEALTH NEEDS IN SCHOOL

This student has the following problems, which may adversely affect his or her education experience (*explain below*):

❑ Cardiac ❑ Chronic Disease ❑ Physical Dysfunction ❑ Hearing ❑ Vision
❑ Behavioral/Social/Emotional/Mental ❑ Speech/Language

PLEASE attach an EMERGENCY ACTION PLAN(s) for the following conditions:

❑ Anaphylaxis (Food /Sting Allergy) Plan ❑ Asthma Plan ❑ Diabetes Plan ❑ Seizure Plan ❑ Other

Comments and recommendations (additional information about any of the above conditions / assessments): _____

_____

_____

❑ **ALLERGIES:** _____

❑ This student may participate fully in the school program, including physical education, activities, sports, and co-curricular activities.

❑ This student may participate in the school program with the following restriction/adaptation (*specify reason and restriction*):

_____

❑ Yes ❑ No I would like to discuss information in this report with the school nurse.

Student's most recent PHYSICAL EXAM was done on: _____/_____/_____ (Date)

_____ _____ _____ _____

Signature of Health Care Provider **Name/Group Practice (Please Print)** **Phone** **Date**

3/2015 bmw/plc