

BELLEVUE SCHOOL DISTRICT

MEDICAL HISTORY AND PHYSICAL EXAMINATION REPORT

PARENTS: Please complete this section:

Name _____ M / F. School _____ Grade _____

Birth date: [][][] [][][] [][][]

Physician's name: _____ Phone: _____ Today's Date: _____

Past Medical History:

Has your child been seriously ill? _____ Had an operation? _____

Had any serious accident? _____

Please explain: _____

Parent's signature

PHYSICIAN: Please complete this section:

Please circle any present health concern:

Bee sting allergy / allergies / asthma / diabetes / congenital anomalies / emotional problems / urinary difficulties hearing difficulties / visual difficulties / abnormal bleeding / scoliosis / seizures / cardiac difficulties

Other: _____

Please note: All life threatening health conditions/allergies and significant asthma conditions require a health care plan prior to attending school (WAC: 180-38-045)

ANY medication* and dosage (list): _____

*If ANY MEDICATION IS TO BE GIVEN AT SCHOOL – HEALTH CARE PROVIDER AND PARENT MUST COMPLETE AND SIGN SEPERATE MEDICATION AUTHORIZATION FORM.

Student's limitations teachers should know: _____

I have known this student since: _____ IMMUNIZATIONS ARE COMPLETE?*

*IMMUNIZATION UPDATE: Please update Certificate of Immunization Status form with all dates if needed IMMUNIZATIONS MUST BE COMPLETE OR STUDENT WILL BE EXCLUDED FROM SCHOOL.

Hepatitis B: 3 doses required for school entry. Timelines when given are very important!

DTap/DT/Tdap/Td: Up to 5 doses DTAP required for school entry. Timelines when given are very important!

Polio: 4 doses IPV or OPV required for school entry.

MMR: 2 doses required for school entry. OR blood test showing immunity to measles, mumps, rubella.

Varicella: For K-3 grade, 2 doses required or PROVIDER reported history of disease. Grades 4 & 5, 1 dose or parented reported history of disease.

I have examined _____ and find him / her physically able to participate in:

[] 1. No physical activity.

[] 2. Limited physical activity. Please explain nature and duration of limitation:

[] 3. Full physical education.

Physician's Stamp _____

Physician's signature _____ Date _____