KAUKAUNA AREA SCHOOL DISTRICT
STUDENT HEALTH EXAMINATION

Student Name _____ D.O.B. _____
School _____ Grade _____
Physician/Nurse Practitioner _____ Date _____

Please have your physician/nurse practitioner fill out the following:

PHYSICAL EXAMINATION

Date of exam _____

Allergies _____ Blood Pressure _____

Height _____ Weight _____

Peak flow baseline _____

	Within Normal Limits			Within Normal Limits	
	YES	NO		YES	NO
Skin			Heart		
Eyes			Lungs		
Vision			Abdomen		
Ears			Back		
Hearing			Extremities		
Nose & Throat			Nutrition		
Mouth			Optional:		
Dental			T.B. Test		
Neck			Lead Screen		

Comments _____

_____

_____

Immunization Status / Up to date Yes / No
Immunizations given at this exam _____

Is this student on any routine medication? Yes / No Explain _____

_____

_____

OVER ⟶

Do you wish to see this student again? Yes / No When_____

Are you referring this student to another professional? Yes / No
If so whom? _____

Recommendations for Student's School Program

Does this student have any specific health needs which should be addressed during the school day? Yes / No
Explain _____

_____

Does this student have any restrictions for physical education? Yes / No
Explain _____

_____

Other comments or recommendations _____

_____

_____

_____ _____
Signature of Physician/Nurse Practitioner Date

Please send completed exam to:

Park Elementary School
Health Office
509 Lawe Street
Kaukauna, WI 54130