

BOULDER VALLEY DISTRICT RE-2
SCHOOL HEALTH PROGRAM
REPORT OF PHYSICAL EXAMINATION

STUDENT _____ BIRTHDATE _____

ADDRESS _____ SCHOOL _____ GRADE _____

A. IMMUNIZATION HISTORY: Give date of immunizations.

VACCINE	ENTER DATE EACH IMMUNIZATION WAS GIVEN				
DIPHTHERIA-TETANUS PERTUSSIS (DTP)					
-OR- TETANUS-DIPHTHERIA					
POLIO					
HAEMOPHILUS INFLUENZA TYPE b (ENTER MONTH, DA Y, YEAR)					
MEASLES (ENTER MONTH, DAY, YEAR)			Written evidence of laboratory tests showing immunity to measles, mumps, and rubella is acceptable. Attach written proof to this certificate or record test results and dates in the boxes at left.		
MUMPS (ENTER MONTH, DAY, YEAR)					
RUBELLA (ENTER MONTH, DAY, YEAR)					
HEPATITIS B (ENTER MONTH, DAY, YEAR)					
VARICELLA (CHICKEN POX)			History of disease: yes _____ Year (optional) _____		

NAME OF EXAMINER _____

(PLEASE PROVIDE THE FOLLOWING IF INDICATED)

URINALYSIS _____

HGB/HCT _____

TB SKIN TEST TYPE _____

DATE OF TB TEST _____

DATE READ/RESULT _____

B. HEALTH HISTORY: (Include significant illnesses such as rubeola, surgeries, injuries, chronic, or recurring illnesses, allergies, or pertinent developmental history)

C. SCREENING TESTS: (If performed in physician's office)

VISION: WITHOUT GLASSES R _____ L _____ HEARING/ HOW TESTED _____
WITH GLASSES R _____ L _____ RESULTS _____

D. PHYSICAL EXAMINATION: (Code-satisfactory=OK; not satisfactory= x; not examined =0)

HEIGHT: _____ % WEIGHT: _____ % B/P: _____ PULSE: _____

Appearance _____	Heart _____
Nutrition _____	Chest / Lungs _____
Head/Neck _____	Abdomen _____
Eyes _____	Genitalia _____
Ears _____	Lymph Nodes _____
Nose/Throat _____	Skin _____
Mouth / Teeth _____	Skeletal/ Scoliosis _____
	Neurological _____

SUMMARY OF FINDINGS, LIMITATIONS AND RECOMMENDATIONS: _____

CURRENT MEDICATIONS: (If needed at school, complete Medication Administration Authorization Form)

E. PHYSICAL EDUCATION RESTRICTIONS: _____

Signature of Examiner: _____

Date of Exam: _____ Print Name of Examiner: _____

Address: _____

Phone: _____

ATHLETIC DEPARTMENT
BOULDER V ALLEY SCHOOL DISTRICT RE-2
SCHOOL HEALTH PROGRAM
STATEMENT BY PHYSICIAN FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined _____ and that the student was found Physically fit to engage in middle level or senior high school baseball, basketball, cross country, football, golf gymnastics, skiing, swimming, tennis, track and field, wrestling, volleyball, soccer, lacrosse, and softball. (Please cross out any sport in which student should not participate.)

Examiner's Signature _____ CHSAA Provider # _____

(CHSAA requires signature of Physician or Nurse Practitioner or Physician's Assistant)

Date of examination: _____

PLEASE COMPLETE BOTTOM PROTION OF THIS FORM FOR ANY STUDENT IN GRADES 7 THROUGH 12 WHO COMPETES WITH STUDENTS FROM ANOTHER SCHOOL IN EITHER EXTRAMURALS, INTRADISTRICT OR INTERSCHOLASTIC ATHLETICS, INCLUDING SPECIAL OLYMPICS.