

Oregon Episcopal School
6300 Southwest Nicol Road
Portland, Oregon 97223
(503) 246-7771
FAX to Nurses: (503)416-9803



STUDENT PHYSICAL REPORT

Grade/Year _____ Date of Birth _____

Student Name _____

Student Address _____ Home Phone _____

Parent Name _____

TO THE HEALTH CARE PROVIDER: Please complete the front side of this form; the reverse side should be completed by the parent. Thank you.

Date of Examination _____

Student's: Height _____ Weight _____ Scoliosis Check _____ Blood Pressure _____

REQUIRED: Vision Check _____ Hearing Check _____ OPTIONAL: TB Skin Test: Date _____ Results: _____

Immunizations given in the past year: Type/Date _____ Type/Date _____

Is this student taking any medication(s) on a regular basis? YES ___ NO ___ If yes, please specify medication(s) and conditions for use: _____

ONGOING HEALTH CONCERNS: _____

ALLERGIES AND/OR ASTHMA: YES ___ NO ___ (Please list type, reaction, and any medications used)

What precautions are required in the school setting? _____

PRIOR HEAD INJURY: YES ___ (date) _____ NO ___ UNKNOWN ___

Please describe any **PHYSICAL OR EMOTIONAL CONCERNS** that would affect participation in academics, school activities, PE, or sports:

Name and Address of Health Care Facility _____

Phone # _____

Signature of Health Care Provider _____

*****PARENT: PLEASE COMPLETE AND SIGN REVERSE SIDE*****

*******FOR COMPLETION BY PARENT*******

STUDENT'S HEALTH HISTORY

-Does your child have any allergies: [] No [] Yes - Please specify & describe type of reaction: _____

Is medication required? [] No [] Yes

Medication(s): _____

**-Does your child have asthma or other respiratory illness: [] No [] Yes
Please specify: _____**

Is medication required? [] No [] Yes

Medication(s) _____

Does your child pre-treat with an inhaler before exercise or certain activities? [] No [] Yes

-Is your child currently taking any other medications? [] No [] Yes; Please list medication(s) & reason:

-Does your child have, or do you suspect, any hearing, speech, or vision difficulties?

[] No [] Yes (If yes, please specify testing and results, if any.)

-Does your child require academic accommodations due to learning difference?

[] No [] Yes (If yes, please specify testing and results, if any.)

-Has your child had any serious injuries, including head injuries, or operations?

[] No [] Yes (Please list & give dates)

-Please check any of the following illnesses your child has had and list dates.

[] Chickenpox [] Heart Condition [] Seizure Disorder
[] Chronic Ear Infections [] Migraines [] Other _____
[] Diabetes [] Meningitis

-Does your child have any emotional issues which should be brought to the school's attention?

[] No [] Yes (Please indicate below and include approximate dates)

[] Depression [] Attention Deficit Disorder [] Stress-related illness
[] Anorexia/Obesity [] Self-Harm [] Other _____

Parent Signature

Date