STUDENT PHYSICAL REPORT
Grades PK – 6 only

Oregon Episcopal School

Grade/Year: _____ Date of Birth: _____

Student Name: _____

Parent Name(s): _____

**********FOR COMPLETION BY HEALTH CARE PROVIDER**********

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: ____

ONGOING HEALTH CONCERNS: _____

Is this student taking any medication(s) on a regular basis? ❑ YES ❑ NO

If yes, please specify medication(s) and conditions for use: _____

_____

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 or school activities/School trips (i.e. - anxiety, depression, stress related illness, migraines, eating issues/disorder, etc.)

_____

_____

Name and Address of Health Care Facility: _____

_____

Phone # _____

Signature of Health Care Provider: _____

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

Oregon Episcopal School
6300 Southwest Nicol Road, Portland, Oregon USA 97223 Ph. 503-246-7771 Fax 503-768-3140 www.oes.edu

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

STUDENT'S HEALTH HISTORY

Student Name: _____ Grade/Year: _____

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: _____

_____

Has your child had or do you suspect any hearing, speech, or vision difficulties? ❑ No ❑ Yes

Please specify: _____

Has your child been diagnosed with a learning or neurodevelopmental disorder? ❑ No ❑ Yes

Please specify diagnosis and any academic accommodations that have been used in the past: _____

_____

Has your child had any of the following medical conditions?

❑ Anxiety ❑ Chronic ear infections ❑ Chronic gastrointestinal condition

❑ Depression ❑ Diabetes ❑ Eating disorder ❑ Heart condition

❑ Migraines ❑ Seizure disorder ❑ Self harm ❑ Stress related illness

❑ Other _____

Has your child had any serious injuries, including head injuries, or operations? ❑ No ❑ Yes

Please list and give dates: _____

_____

_____ _____

Parent Signature **Date**

Return completed form to the Lower or Middle School office or fax it to 503-768-3140.

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