St. Charles Campus † 449 Conkey St., Burlington, WI 53105 † 262-763-2848 † www.ourbcs.org

## Student Health Condition & Current Medications

Last Name: ____________________ First Name:________________ MI: ___ Birthdate: ____/____/_______

Address: ______________________________________________________________________________

Parent/Guardian: _____________________________________ Family Physician: ______________________

*** If NO HEALTH CONDITIONS** - please check here __________, then sign & date the bottom of this page.

Health Conditions: (Check all that apply & return this COMPLETED form to the school.)

**Yes No Any condition requiring medication - be sure to list that below**

_____ _____ Condition which could affect school activity: ________________________________________

_____ _____ Asthma: ______________________________________________________________________

_____ _____ Diabetes : ____________________________________________________________________

_____ _____ Heart Problems: _______________________________________________________________

_____ _____ Cancer: ______________________________________________________________________

_____ _____ Arthritis - Rheumatoid / Fibromyalgia: ____________________________________________

_____ _____ Bleeding Disorder: _____________________________________________________________

_____ _____ Seizure Disorder: ______________________________________________________________

_____ _____ Migraines - Headache / Abdominal: _______________________________________________

_____ _____ Vision Impairment - Glasses / Contacts / Blind: ______ Right Eye ______ Left Eye

_____ _____ Hearing Impairment - Hearing Aid: ______ Right Ear ______Left Ear

_____ _____ ADHD / ADD: __________________________________________________________________

_____ _____ Depression / Anxiety: ___________________________________________________________

_____ _____ Allergies (Be specific in severity, type and reactions seen): _____________________________

_____ _____ Food: _________________________________________________________________________

_____ _____ Insect: ________________________________________________________________________

_____ _____ Medication: ____________________________________________________________________

_____ _____ Environmental: _________________________________________________________________

**Medications:** (List ALL medications that your child is currently taking & the reason)

| Medication Name | Purpose |
|---|---|
| | |
| | |

________________________________________________________________ Date: _______/_____/_________

**Signature of Parent /Guardian REQUIRED**

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**Physical Examination**

Last Name: ____________________ First Name:________________ MI: ___ Birthdate: ____/____/_______

Height: _________ Weight: ________ Lead: _______ B/P: ________ Pulse: ________

| | Normal | Abnormal | Not Evaluated |
|---|---|---|---|
| General Appearance | ( ) | ( ) | ( ) |
| Posture, Gait | ( ) | ( ) | ( ) |
| Speech | ( ) | ( ) | ( ) |
| Head | ( ) | ( ) | ( ) |
| Skin | ( ) | ( ) | ( ) |
| Eyes | ( ) | ( ) | ( ) |
| Ears, Internal Aspects | ( ) | ( ) | ( ) |
| Speech | ( ) | ( ) | ( ) |
| Nose, Mouth, Pharynx | ( ) | ( ) | ( ) |
| Teeth | ( ) | ( ) | ( ) |
| Heart | ( ) | ( ) | ( ) |
| Lungs | ( ) | ( ) | ( ) |
| Abdomen | ( ) | ( ) | ( ) |
| Bones, Joints, Muscles | ( ) | ( ) | ( ) |
| Neurological / Social | ( ) | ( ) | ( ) |
| Gross Motor | ( ) | ( ) | ( ) |
| Fine Motor | ( ) | ( ) | ( ) |
| Glands (lymphatic/thyroid) | ( ) | ( ) | ( ) |
| Muscular Coordination | ( ) | ( ) | ( ) |

Acute / Chronic Conditions: (Diabetes / Asthma / Etc.) ____________________________________

Restrictions / Recommendations: ___________________________________________________

**Physician Signature:** __________________________________________ Date: ______________

Physician Address: __________________________________________Phone No: _____________