KPS Health Services 7th Grade Health/Physical Form
Please complete, sign and return to school after physical exam completed.
This form is required for all students entering 7th grade.

Student Name ________________________________ Date of birth ___________
Student Doctor ___________________________ School _____________________

ALLERGIES____

****Insect, bee sting allergies or food allergies require a written plan from your medical provider with specific instructions for school.**

Please check the box if your student has any of the following:

Condition		
*Asthma/Breathing condition	☐Yes	☐No
*Diabetes	☐Yes	☐No
*Seizure condition	☐Yes	☐No
*Migraine headaches	☐Yes	☐No
Cardiac/heart conditions	☐Yes	☐No
Kidney/urinary tract problems	☐Yes	☐No
Bowel/digestive difficulties	☐Yes	☐No
Any chronic disease/disorder	☐Yes	☐No
Psychiatric or behavioral diagnosis	☐Yes	☐No
Emotional concerns	☐Yes	☐No
Frequent ear infections	☐Yes	☐No

Other ________________________________

"*" These conditions require health action plan. Please see School Nurse.

If you checked any of the above, please provide more information about current condition and how it is managed or treated:

____
____
____

Does your student have any hearing or vision concerns/conditions? ___ Yes ___ No
If yes, please provide more information.
____
____

Does your student wear glasses? ___Yes ___No
Contacts? ___ Yes ___ No

Has your student ever had ear tubes? ___Yes ___No
If yes, are the tubes still in place? ___ Yes ___ No

Has your student had any surgeries?
___ Yes ___ No If yes, please list:
____
____

Please list the name and dose of any medications your will be taking:
At School ___________________________________
____
At home ____________________________________
____

You will be required to complete a medication permission form for your student to take ***any*** medication at school. The form must be completed for all new medications and each time there is a change in dosage, time or administration. **No medication is provided by the school, this includes Tylenol, Ibuprofen and cough drops**. Medication must be brought to the school by the parent/guardian in the original labeled container. **Students may not carry medication at school. All medications must be kept in the Nurses' office.**

I, as parent/guardian of ______________________, give my permission for the School Nurse, to contact the above mentioned doctor regarding the health status of my child. I understand this information will be kept confidential and I will be informed of any contact.

I verify the above information is correct to the best of my knowledge.

Parent Signature____ Date ______________________

Please attach copy of current immunizations. **Physical exam to be completed on back of form.**