**PHYSICIAN'S EXAMINATION FOR BRUNSWICK SCHOOL DEPARTMENT**
**(To be completed by student's physician)**

Name _____ M/F _____ D.O.B. _____

Grade _____ School _____

**MEDICAL HISTORY**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | History of Anaphylaxis *(If yes please attach Allergy Action Plan)* |
| | | Please specify allergen(s) _____Epinephrine prescribed?: Yes No |
| ☐ | ☐ | Asthma (*If yes please attach Asthma Action Plan)* |
| ☐ | ☐ | Diabetes: Type I Type II |
| ☐ | ☐ | Seizure Disorder |
| ☐ | ☐ | Other (please specify)_____ |

***Please include a physician's order for any medications to be administered at school***

**PHYSICAL EXAMINATION** **Date of Physical Exam:_____**

Height _____ Weight _____ BMI _____BP_____HR_____RR_____

**IMMUNIZATIONS**

***Please attach immunization form. If immunizations are not up to date please include physician statement on the BSD Exemption Form.***

**COMMENTS**

This student has the following concern(s) that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor
☐ Emotional/Social ☐ Behavioral ☐ Other

Comments:_____
_____
_____

**RECOMMENDATIONS**

No ☐ Yes ☐ this student may participate fully in the school program including physical education and competitive sports. If YES please provide completed Athletic Participation form for Jr. High and High School Students.
If No, please list restricions:_____

_____ _____
Physician Name (printed) Physician Signature
(rev 06/17)

Date:_____