



BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
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“Optimal health and wellness is essential for proper development and learning.”

Physical Examination

Student’s Name: _____ Birthdate: _____

Address: _____ School: _____ Grade: _____

Parent / Guardian Name: _____ Phone: _____

	Normal	Abnormal	Referral	Not Evaluated	
General Appearance	()	()	()	()	
Posture, Gait	()	()	()	()	
Speech	()	()	()	()	
Head	()	()	()	()	Ht: _____
Skin	()	()	()	()	
Eyes, External Aspects	()	()	()	()	Wt: _____
Ears, External Aspects	()	()	()	()	
Ears, Internal Aspects	()	()	()	()	B/P: _____
Nose, Mouth, Pharynx	()	()	()	()	
Teeth	()	()	()	()	Pulse: _____
Heart	()	()	()	()	
Lungs	()	()	()	()	Resp: _____
Abdomen (include hernia)	()	()	()	()	
Bones, Joints, Muscles	()	()	()	()	
Neurological / Social	()	()	()	()	
Gross Motor	()	()	()	()	
Fine Motor	()	()	()	()	
Glands (lymphatic/thyroid)	()	()	()	()	
Muscular Coordination	()	()	()	()	

Allergies (Be Specific): _____ Current Medications: _____

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

Immunizations Given Today: ()DTP ()Polio ()Hib ()MMR ()Varicella 1 - 2 ()HBV 1 - 2 – 3
()Other _____ () Up-to-date (please attach record)

Restrictions / Recommendations: _____

Physician Signature: _____ Date: _____

Physician Address: _____ Phone No: _____