COLCHESTER SCHOOL DISTRICT

Dear Parents,

The Colchester School District's Student Health Policy strongly recommends that each student entering our school system for the first time have a physical examination. This policy recognizes the importance of the family physician in identifying health problems, prescribing appropriate medication, and providing a link between a child's medical needs and our school health care professionals. Although physical exams completed during the past three months are acceptable, all parents of new students should request that their physicians complete the form on the opposite side of this letter. Please return this form to:

Deborah M. Deschamps, M.S.N./R.N.
District Supervisor of Building Nurses
Colchester School District
P.O. Box 900
Colchester, VT 05446

Any students who participate in intramural or interscholastic sports are also addressed in this district policy. Their requirement is to produce evidence of a thorough physical examination conducted by their family physician every two years.

On behalf of the Colchester Board of Education, we thank you for your cooperation and compliance with the specifics of this important school district policy.

Sincerely,

Deborah M. Deschamps, M.S.N./R.N.
District Supervisor of Building Nurses

Amy Minor
Superintendent of Schools

COLCHESTER SCHOOL DISTRICT
MEDICAL EXAMINATION FORM

Please have your physician fill out this form or attach a copy of your child's physical.

Student Name: _____ Student #: _____

Date of Birth: _____ Male_____ Female_____ School: _____Grade: _____

Student Address: _____ Phone #: _____

TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

Significant Medical History/Handicaps Comments (attach separate sheet if necessary): _____

_____

_____

This child may participate in:

_____ a. Full physical activity including physical education.

_____ b. Modified physical activity because of _____

_____

_____

_____ c. Limited physical activity because of _____

_____

_____

Height: _____

Weight: _____

Vision: _____

Hearing: _____

Blood Pressure: _____

Exam Date: _____

Physical Examination

Scalp, Skin, Hair	_____
Nose and Throat	_____
Teeth and Gums	_____
Thyroid Gland	_____
Lymph Nodes	_____
Heart	_____
Lungs	_____
Abdomen	_____
Bones and Joints	_____
Muscle Tone	_____
Posture	_____
Nervous System	_____
Genitalia	_____
Nutrition	_____
Hernia	_____
Orthopedic	_____
General Physical Status	_____
General Emotional Status	_____
Other	_____

Please attach to this form a current immunization record from your child's health care provider.

_____ M.D.
Signature

_____
Address

16-021