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
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.  Height: __________________________

_____ b. Modified physical activity because of __________
____________
____________

_____ c. Limited physical activity because of __________
____________
____________

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