District 49 Early Childhood Education

COLORADO
Office of Early Childhood
Department of Human Services

Student Physical Form

(to be completed and signed by a health care provider)

Child's Name:_____ Date of Birth:_____

Past illnesses: approximate date for those that apply:

Chicken Pox	Rubella	Asthma
Diabetes	Mumps	Polio
Hay Fever	Ear infections	Epilepsy
Rheumatic Fever	Whooping Cough	_____
_____	_____	_____

Please give location of any pigmented lesion, birthmarks or other permanent scarring:

_____

List any dietary needs/restrictions:_____

_____

Medications prescribed:_____

_____

Vision:_____ Hearing:_____

Current Health Status (circle one): Excellent Good Fair Poor

Please attach a copy of all immunizations and dates given

Examination Date:_____ Expiration Date:_____

Health Care Provider Name (print)_____

Health Care Provider Signature_____

Address_____ City_____ Zip_____

Phone_____ Fax_____

D49 will accept this physical form or the form provided by physician/health care provider (form must include expiration date)