Wichita Public Schools
Division of Student Support Services
DEPARTMENT OF HEALTH SERVICES
HEALTH EXAM REPORT

Student Name _____ Birthdate _____ Grade _____ School _____

PARENTS - Kansas State Law requires a health assessment for all children less than 9 years of age entering a Kansas school for the first time. Please obtain an examination for your child from your Health Care Provider.

Nutritional Status _____ Ht. _____ Wt. _____ BMI _____ BP _____
EENT - Eye, Ear, Nose &Throat _____
Respiratory System _____
Asthma ☐ Yes ☐ No Comment - _____
Allergies ☐ Yes ☐ No List Allergies - _____
Cardio-Vascular System _____
Heart Disease ☐ Yes ☐ No Limitation - _____
Gastrointestinal System _____
Genitourinary System _____
Musculo-Skeletal System _____
Scoliosis ☐ Yes ☐ No Comment - _____
Central Nervous System _____
Seizure Disorder ☐ Yes ☐ No Comment - _____
Endocrine System _____
Diabetes Mellitus ☐ Yes ☐ No Comment - _____
Mental Health Concern ☐ Yes ☐ No Comment - _____
Social Development - family, peer, school _____
Please comment on health condition(s) _____
Are routine medications prescribed? ☐ Yes ☐ No Comment - _____
If medication is to be given at school, please complete the ***Authorization for Medication/Procedure at School*** form.
What are your health recommendations - _____
_____

Date _____ _____ _____
Printed Name of Physician/ARNP/PA Signature of Physician/ARNP/PA

5.4007S February 2018

Wichita Public Schools
Division of Student Support Services
DEPARTMENT OF HEALTH SERVICES
HEALTH EXAM REPORT

Student Name _____ Birthdate _____ Grade _____ School _____

PARENTS - Kansas State Law requires a health assessment for all children less than 9 years of age entering a Kansas school for the first time. Please obtain an examination for your child from your Health Care Provider.

Nutritional Status _____ Ht. _____ Wt. _____ BMI _____ BP _____
EENT - Eye, Ear, Nose &Throat _____
Respiratory System _____
Asthma ☐ Yes ☐ No Comment - _____
Allergies ☐ Yes ☐ No List Allergies - _____
Cardio-Vascular System _____
Heart Disease ☐ Yes ☐ No Limitation - _____
Gastrointestinal System _____
Genitourinary System _____
Musculo-Skeletal System _____
Scoliosis ☐ Yes ☐ No Comment - _____
Central Nervous System _____
Seizure Disorder ☐ Yes ☐ No Comment - _____
Endocrine System _____
Diabetes Mellitus ☐ Yes ☐ No Comment - _____
Mental Health Concern ☐ Yes ☐ No Comment - _____
Social Development - family, peer, school _____
Please comment on health condition(s) _____
Are routine medications prescribed? ☐ Yes ☐ No Comment - _____
If medication is to be given at school, please complete the ***Authorization for Medication/Procedure at School*** form.
What are your health recommendations - _____
_____

Date _____ _____ _____
Printed Name of Physician/ARNP/PA Signature of Physician/ARNP/PA

5.4007S February 2018