WEST CHESTER AREA SCHOOL DISTRICT
NOTICE OF PHYSICAL EXAMINATION

To the Parent or Guardian of__________________________________________:

Physical examinations are required of children entering kindergarten and/or 1st, 6th, and 11th grades and students transferring from out-of state pursuant to Article XIV, School Health Services, of the Public School Code and concomitant regulations, 28 Pa. Code 32.1-23.87, Health Services.

You have given written permission for the school Health Care Provider of the West Chester Area School District to complete this physical examination. In compliance with the School Health Act, these medical examinations will require the removal of sufficient clothing to insure a complete exam. This will include a hernia/testicle examination for males. It will not include a breast or genital examination for females.

Your child is to be examined this year and you are invited to be present for this exam to be given in the School Health Office.

_________________________ (Date) ___________________ (Time)
I will be present_______ I will not be present ____________.

To make the examination more useful for the health needs of your child, PLEASE SUBMIT THE INFORMATION REQUESTED BELOW:

Allergy____________ Influenza_______ Epilepsy_______ Asthma ______________ (hives, drugs, etc.)
Menstrual cramps________________ Scarlet Fever____________ Bronchitis _____________ Chicken Pox ______________
Sinus Infection________________ Tonsilitis________ Rheumatic Fever________ Wisdom Teeth ________________
Lyte Disease_____________ T.B. Self_____________ T.B. Family_________ Cleft Palate ______________
Pneumonia___________ Hernia (rupture)________ Enuresis (bed wetting)________ Whooping Cough___________
Diabetes_________________ Heart Condition_________ Mono.__________ Other ______________
Operations/ Date for: Appendicitis_________ Ruptured Hernia__________ Tonsillectomy_______ Adenoidectomy_______
Heart Defect__________________________ Other____________________________
Fractures of Bones: ____________________________________________________________

Does your child have frequent colds?_____________________________________________
Is your child on any medications?________________________ If YES, what and why?_______________________________
Is your child under medical treatment at present?_______ Why?____________________________
Name of Health Care Provider(s):_____________________________________________________

NOTE: Please list any special conditions/concerns you wish to call to the attention of the examining Health Care Provider:_____________________________________________________

PLEASE SIGN AND RETURN TO THE SCHOOL NURSE
________________________________________________________ Date:

Parent / Guardian Signature

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