

Red Cedar School

P.O. Box 393 · 246 Hardscrabble Road · Bristol, VT 05443
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Health Information Form – Part B – Physician’s Form

*To be completed by a licensed physician, state approved nurse practitioner, or physician’s assistant.
Medical examination is required within 18 months prior to the beginning of school.*

Name of Student: _____ **Date examined** _____

Height _____ **Weight** _____ **Hgb/Hct** _____

BP _____ **Pulse** _____ **Hearing** (if abnormal, please attach a copy)

Left _____ Right _____

Vision

Right: Near _____ Far _____

Left: Near _____ Far _____

Both: Near _____ Far _____

Muscle Balance (pass/fail) _____

Urinalysis _____

Known Allergies: _____

Problems, conditions or developmental issues of which the school should be aware: _____

The student is under the care of a physician for the following conditions: _____

Description of any limitations or restrictions on school activities, including sports, wilderness trips and other physical activities: _____

Medications being taken: _____

Medication to be taken at school (including epipen, inhaler, or other prescribed medications)

Medication: _____

Directions: _____

Beginning Date: _____ End Date: _____

Reason for giving: _____

Signature of physician / nurse practitioner / physician’s assistant: _____

Date: _____

Please attach schedule of immunizations