

Bureau of Community Health Systems Division of School Health

## Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

## PARENT / GUARDIAN / STUDENT:

Complete page one of this form <u>before</u> student's exam. Take completed form to appointment.

GENTOURUNARY: Has the student  YES NO  Other  Other  Asthma Lahemia Diabetes Infraction  Other  Other  Asthma Lahemia Diabetes Infraction  Other  Sever had surgery?  Sever had surgery?  Sever had surgery?  Shed a history of training training training problems or head with the less 12 months?  Sever had surgery?  Shed a history of their power without or is missing a kidney, an eye, a sestice (males), spleno, or any other organ?  Shed history of being born without or is missing a kidney, an eye, a sestice (males), spleno, or any other organ?  Shed history of being born without or is missing a kidney, an eye, a sestice (males), spleno, or any other organ?  Shed history of being born without or is missing a kidney, an eye, a sestice (males), spleno, or any other organ?  Shed history of being born without or is missing a kidney, an eye, a sestice (males), spleno, or any other organ?  Shed history of being born without or is missing a kidney, an eye, a sestice of the history of the company of the service?  Shed history of being born without or is missing a kidney, an eye, a sestion of the history of the company of th	And the second s			xam Gender: □ Male □ Female		
Medicines	Medicines and Allergies: Please list all prescription and o	ver-the-co	unter me	edicines and supplements (herbal/nutritional) the student is currently to	aking:	
Medicines	Does the student have any allernies?   No.   Tyes (If yes	list speci	fic allero	v and reaction \		
Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.  GENERAL HEALTH: Has the student  YES NO  GENERAL HEALTH: Has the student  YES NO  JAshma Dennetical Conditions? If so, please identify:  JEVer had surgery?  JEVer had surgery?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the least 12 months?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the least 12 months?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the least 12 months?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the head 12 months?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the head?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the head?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the head?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the head?  JEVER had shich or being born without or is missing a kidney, an eye, a establed make a student face in the head?  JEVER had a foothy the head that caused confusion, prolonged estable head in high or both with history of a mental variation of the head in history of the fall with hi	STATE OF THE STATE	, not opcor	no ancig			
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1. Any ongoing medical conditions? If so, please identify:    Asthma   Anemia   Diabetes   Infection	Complete the following section with a check mark in t	he YES o	r NO co	lumn; circle questions you do not know the answer to.		
Data A a history of urinary tract infections or bedwetting?  2. Ever stayed more than one night in the hospital?  3. Ever had surgery?  4. Ever had a seture?  5. Had a history of being born without or is missing a kidney, an eye, a testeled (males), spleen, or any other organ?  6. Ever become ill while exercising in the heat?  7. Had frequent musulec cramps when exercising?  HEADNECKISPINE: Has the student  8. Had headsches with exerciser?  9. Ever had a head injury or concussion?  10. Ever had a head injury or concussion?  11. Ever had a head injury or concussion?  12. Ever had a head injury or concussion?  13. Notice of remony problems?  14. Ever had a surgery is the student  15. Been prosibed glasses or contact lenses?  16. Ever been unable to move arms or legs after being hit or falling?  17. Ever had new arms or legs after being hit for falling?  18. Ever had new arms or legs after being hit or falling?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy, molivation, interest or enthalisation?  19. Shown a general loss of energy of the following? I so, check all that apply:  19. Had a stimular than a sheart problem? If so, check all that apply:  19. Had a stimular that equired a brace, cast, cru	GENERAL HEALTH: Has the student	YES	NO	GENITOURINARY: Has the student	YES	N
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### Received a recommendation to gain or lose weight?  ###################################	14 Had any problem with his/her eyes (vision) or had a history of an					
FAMILY HEALTH:   YES						
Family HACTH:   YES	HEART/LUNGS: Has the student	YES	NO			
Anemia/blood disorders   Inherited disease/syndrome   Asthma/lung problems   Kidney problems   Seizure disorder   Inherited disease/syndrome   Asthma/lung problems   Kidney problems   Seizure disorder   Inherited disease/syndrome   Asthma/lung problems   Kidney problems   Seizure disorder   Inherited disease/syndrome   Asthma/lung problems   Seizure disorder   Inherited disease/syndrome   Asthma/lung problems   Seizure disorder   Inherited disease/syndrome   Asthma/lung problems   Seizure disorder   Inherited disease/syndrome   Inherited d					YES	No
Section   Sect	all that apply:  ☐ High blood pressure ☐ High cholesterol  ☐ Been told by the doctor to have a heart test? (For example,			□ Anemia/blood disorders □ Inherited disease/syndrome □ Asthma/lung problems □ Kidney problems □ Behavioral health issue □ Seizure disorder □ Diabetes □ Sickle cell trait or disease		
De Had discomfort, pain, tightness or chest pressure during exercise?  De Had discomfort, pain, tightness or chest pressure during exercise?  De Had discomfort, pain, tightness or chest pressure during exercise?  De Had discomfort, pain, tightness or chest pressure during exercise?  De Had discomfort, pain, tightness or chest pressure during exercise?  De High blood pressure de High bloo	9. Had a cough, wheeze, difficulty breathing, shortness of breath or			43. Is there a family history of any of the following heart-related		
## Felt his/her heart race or skip beats during exercise?  ## As the student  ## Pas the student  ## Pas the student  ## High blood pressure						
Has the student  2 Had a broken or fractured bone, stress fracture, or dislocated joint?  3 Had an injury to a muscle, ligament, or tendon?  4 Had an injury that required a brace, cast, crutches, or orthotics?  5 Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?  6 Had joints that become painful, swollen, feel warm, or look red?  7 Has the student  YES NO  7 Had any rashes, pressure sores, or other skin problems?  8 Ever had herpes or a MRSA skin infection?  YES NO  That to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange of the information is true and complete. I give my consent for an exchange						
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	ereby certify that to the best of my knowledge all ealth information between the school nurse and h	ot the in ealth car	rormati e provid	ion is true and complete. I give my consent for an exchan ders.	ge of	

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY	(pag	e 1 of	fthis	form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes \( \Bar{\cup} \) No \( \Bar{\cup} \)
,	CH	ECK C	NE	
Physical exam for grade:  K/1 □ 6 □ 11 □ Other □		*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: ( / )				
Hair/Scalp				
Skin				
Eyes/Vision Corrected 🗆				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities .				
Spine (Scoliosis)				
Other				
TUBERCULIN TEST   DATE APPLIED	DA	TE REA	n .	RESULT/FOLLOW-UP
10 Date Continue 1				RESULTIPOLEOW-UP
	HRON	ic disi	EASES	WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
(Additional space on page 4)				
Parent/guardian present during exan	n: Yes	<b>=</b>	No	
Physical exam performed at: Person	al He	alth C	are Pi	rovider's Office School Date of exam20
Print name of examiner				
Print examiner's office address				Phone
Signature of examiner				
ASTRACTOR OF CAUTITION				MD 🖂 DO 🖂 PAC 🖂 CRNP 🖂

## HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record - OR - insert information below.

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IMMUNIZATION EXEMPTION(S):	8 <b>.</b> 0			1	
Medical Date Issued: Rea	ason:			Date Rescinded:_	
Medical ☐ Date Issued: Rea	ason:			Date Rescinded:_	
Medical Date Issued: Rea	ason:			Date Rescinded:_	
NOTE: The parent/guardian must provide a	written request to the	ne school for a religi	ous or philosophical	exemption.	
	Bootur-i-				
VACCINE	DOCUMENT:	(1) Type of vaccin	e; (2) Date (month	day/year) for each	immunization
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	4	,			
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV				•	
Hepatitis B (HepB)	1	2	3		5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician	Date:	*			
Varicella: Vaccine Disease	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella		2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)		2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
8		2	3	4	5
Influenza Type: TIV (injected)	6	7	8	9	10
LAIV (nasal)	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13		2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
	Other Vac	cines: (Type and	Date)		
					13

rage 4 of 4: ADDITIO	ONAL COMMENTS (F	AREN I / GUARDIA	N / O IUDENT / HE	ALTH CARE PROVI	IDER)		
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