HEALTH EXAMINATION FORM

To participate in sports teams, please complete the Athletic Pre-Participation Physical Evaluation Form <u>in addition</u> to this form

Child's Last Name | First Name | Middle Name | ☐ Female ☐ Male | Date of Birth (*Month/Day/Year)*

Child's Address

City | State | Zip Code

PHYSICAL EXAMINATION

Height ____________

Weight ___________

BMI ____________

Blood Pressure ____/____

DATE OF LAST PHYSICAL EXAM:

_____/______/_________

GENERAL APPEARANCE

Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	HEENT	☐	☐	Back/Spine	☐	☐	Genitourinary
☐	☐	Dental	☐	☐	Neck	☐	☐	Cardiovascular
☐	☐	Abdomen	☐	☐	Skin	☐	☐	Neurological
☐	☐	Lymph Nodes	☐	☐	Language	☐	☐	Psychosocial Development
☐	☐	Extremities	☐	☐	Lungs	☐	☐	Behavioral

DESCRIBE ABNORMALITIES:

DOES THE CHILD/ADOLESCENT HAVE A PAST OR PRESENT MEDICAL HISTORY OF THE FOLLOWING:

☐ Asthma (*check severity & attach MAF/Asthma Action Plan*) ☐ Intermittent ☐ Mild Presistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral Steriod ☐ None

☐ Attention Deficity Hyper Activity Disorder
☐ Anxiety
☐ Bleeding disorders
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Eating disorders
☐ Headaches/Migraines
☐ Orthopedic injury/disability
☐ Previous Surgery
☐ Seizure
☐ Speech, hearing or visual impairment
☐ Stomach/Intestinal disorder
☐ Thyroid Disease
☐ Tuberculosis, latent infection or disease
☐ Other (Specify) ________________________________

Explain all checked items above or on addendum: ____

Dietary Restrictions (*please list)*: ____ ☐ Lactose Intolerant

Medications *(attach MAF if in-school medication is needed)* ☐ None ☐ Yes (please list)

____

SCREENING TESTS

Hearing

☐ Pure tone audiometry
☐ OAE
☐ Normal ☐ Abnormal
Date: ___/___/_____

Vision

___/___/___ ☐ With Glasses
Acuity *Right* ___/___
Left ___/____
Strabismus ☐ No ☐ Yes
Date: ___/____/_____

Scoliosis

☐ Normal ☐ Abnormal
Date: ___/ ___/____

Tuberculosis

PPD/Mantoux *placed*
Date:___/____/_____
PPD/Mantoux read
Date:____/____/_____
☐ Nl ☐ Abnl ☐ Not Indicated

RECOMMENDATIONS

☐ Full physical activity ☐ Full diet
☐ Restrictions (specify)____
Follow-up Needed ☐ No ☐ Yes **,** for ___________________________

ASSESSMENT ☐ **Well Child** ☐ **Diagnoses/Problems** (explain)

____

____

Health Care Provider (print)

Facility Name

Address | **City** | **State** | **Zip**

Telephone | **Fax**

Health Care Provider Signature | **Date**

PLEASE ATTACH IMMUNIZATION RECORDS