

The Maryland School for the Blind

PART III – SCHOOL HEALTH ASSESSMENT Health Center - School Year 2011-2012

To be completed ONLY by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)
1. Does the child have a diagnosed medication condition? No Yes _____ _____		
2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g. seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) if yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan." No Yes _____ _____		

3. Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	COMMENTS	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		
REMARKS: (Please explain any abnormal findings.)						

4. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI % tile		
Lead Test	Optional	

5. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed below?			
	Yes	No	Comments
Wrestling			
Swimming			
Goal Ball			
Cheerleading			
Track			

_____ has had a complete history and physical examination at our office and has no evident health problem except as noted above.

Physician/Nurse Practitioner Signature

Date

Physician/Nurse Practitioner (Print)

Office Phone Number

Office Fax Number