**The Maryland School for the Blind**

M.D. & Parent

**PART III – SCHOOL HEALTH ASSESSMENT**

**Health Center - School Year 2016-2017**

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 | | | | | | | | | | | | | |
| 1. 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 | | | | | | | | | | | | | |
| 1. 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.) | | | | | | | | | | | | | |
| 1. Screenings | | | | Results | | | | | | | Date Taken | | |
| Tuberculin Test | | | |  | | | | | | |  | | |
| Blood Pressure | | | |  | | | | | | |  | | |
| Height | | | |  | | | | | | |  | | |
| Weight | | | |  | | | | | | |  | | |
| BMI % tile | | | |  | | | | | | |  | | |
| Lead Test | | | | Optional | | | | | | |  | | |
| 1. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed? | | | | | | | | | | | | | |
|  | | | | | Yes | No | Comments | | | | | | |
| Wrestling | | | | |  |  |  | | | | | | |
| Swimming | | | | |  |  |  | | | | | | |
| Goalball | | | | |  |  |  | | | | | | |
| Cheerleading | | | | |  |  |  | | | | | | |
| Track | | | | |  |  |  | | | | | | |
| 1. Contact Sports | | | | | | | | | | | | | |
|  | | | | | Yes | No | Comments | | | | | | |
| Risk of Retinal Detachment | | | | |  |  |  | | | | | | |
| Long Duration of Intense Cardiovascular Activity | | | | |  |  |  | | | | | | |
| Any Weight Bearing Restrictions: i.e., Lifting Weights | | | | |  |  |  | | | | | | |
| Special Requirements for Sun Exposure | | | | |  |  |  | | | | | | |
| Tumbling Activities | | | | |  |  |  | | | | | | |
| Must Wear Eye Protection During Physical Activity | | | | |  |  |  | | | | | | |

Student 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**

CD/LB/MM/cic:5/2/16