**M.D.**



**Medical Part II – History and Physical**

**for overnight students and students participating on a sports team**

**Health Center - School Year 2023-2024**

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. MSB students compete against visually impaired athletes in the Eastern Athletic Association for the Blind and occasionally some local high schools. Some of these activities are contact sports. This physical is required for all students participating in these activities. **Is student allowed to participate in:**
 |
|  | Yes | No | Comments |
| Wrestling/Judo (Contact) | [ ]  | [ ]  |  |
| Swimming (Non-Contact) | [ ]  | [ ]  |  |
| Goalball (Contact) Played only by visually impaired students | [ ]  | [ ]  |  |
| Cheerleading (Non-Contact) | [ ]  | [ ]  |  |
| Track (Non-Contact) | [ ]  | [ ]  |  |
| Soccer (Contact) | [ ]  | [ ]  |  |
| Basketball (Contact) | [ ]  | [ ]  |  |
|  |
| 1. Special Considerations for Contact Sports for this student:
 |
|  | 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/Heat Exposure | [ ]  | [ ]  |  |
| Tumbling Activities | [ ]  | [ ]  |  |
| Must Wear Eye Protection During Physical Activity | [ ]  | [ ]  |  |

**Physician/Nurse Practitioner Signature Date**

**Physician/Nurse Practitioner (Print) Office Phone Number Office Fax Number**

PB/LB/MM/cic:4/13/23