Medical Part 2 – History and Physical for overnight students and students participating on a sports team

Health Center – School Year 2024-25

To be completed ONLY by Physician/Nurse Practitioner

Student's Name (Last, First, Middle): Click or tap here to enter text.

Birthday (Mo. Day Yr.): Click or tap to enter a date.

Sex: [ ]  M [ ]  F

1. Does the child have a diagnosed medication condition? [ ]  Yes [ ]  No
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." [ ]  Yes [ ]  No
3. Evaluation Findings/CONCERNS

Physical Exam

* Head: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Eyes: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* ENT: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Dental: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Respiratory: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Cardiac: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* GI: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* GU: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Musculoskeletal/Orthopedic: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Neurological: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Skin: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Endocrine: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.
* Psychosocial: [ ]  WNL [ ]  ABNL
	+ Comments: Click or tap here to enter text.

Health Area of Concern

* Attention Deficit/Hyperactivity: [ ]  Yes [ ]  No
* Behavior/Adjustment: [ ]  Yes [ ]  No
* Development: [ ]  Yes [ ]  No
* Hearing: [ ]  Yes [ ]  No
* Immunodeficiency: [ ]  Yes [ ]  No
* Lead Exposure/Elevated Lead: [ ]  Yes [ ]  No
* Learning Disabilities/Problems: [ ]  Yes [ ]  No
* Mobility: [ ]  Yes [ ]  No
* Nutrition: [ ]  Yes [ ]  No
* Physical Illness/Impairment: [ ]  Yes [ ]  No
* Psychosocial: [ ]  Yes [ ]  No
* Speech/Language: [ ]  Yes [ ]  No
* Vision: [ ]  Yes [ ]  No
* Other: [ ]  Yes [ ]  No

REMARKS: (Please explain any abnormal findings.) Click or tap here to enter text.

1. Screenings

Tuberculin Test

* Results: Click or tap here to enter text.
* Date Taken: Click or tap to enter a date.

Blood Pressure

* Results: Click or tap here to enter text.
* Date Taken: Click or tap to enter a date.

Height

* Results: Click or tap here to enter text.
* Date Taken: Click or tap to enter a date.

Weight

* Results: Click or tap here to enter text.
* Date Taken: Click or tap to enter a date.

BMI % tile

* Results: Click or tap here to enter text.
* Date Taken: Click or tap to enter a date.

Lead Test

* Results: Click or tap here to enter text.
* Date Taken: Click or tap to enter a date.
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:**

Wrestling/Judo (Contact): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Swimming (Non-Contact): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Goalball (Contact) Played only by visually impaired students: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Cheerleading (Non-Contact): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Track (Non-Contact): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Soccer (Contact): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Basketball (Contact): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.
1. Special Considerations for Contact Sports for this student:

Risk of Retinal Detachment: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Long Duration of Intense Cardiovascular Activity: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Any Weight Bearing Restrictions, i.e. Lifting Weights: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Special Requirements for Sun/Heat Exposure: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Tumbling Activities: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Must Wear Eye Protection During Physical Activity: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Physician/Nurse Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

Physician/Nurse Practitioner Printed Name: Click or tap here to enter text.

Office Phone Number: Click or tap here to enter text.

Office Fax Number: Click or tap here to enter text.

PB/LB/cic:4/3/24