

**BROOKLYN FRIENDS SCHOOL  
STUDENT PHYSICAL EXAMINATION  
SCHOOL YEAR 2009/2010**

**K-12 HEALTH FORM  
PERIODIC EXAM**

The school will act based on the information you give us. It is expected that this form is accurate, complete and up-to-date. This information helps us better care for your child while in school and assists us in promoting the health of our community. Note that **X** indicates a signature is required.

**Part 1 - To Be Completed By Parent and Signed by Physician**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Gender:  M  F Home Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Home# \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Home# \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Person to be notified in case of an emergency if unable to reach parent:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**EMERGENCY CARE AUTHORIZATION:** I give my permission for the school to administer first aid to my child as needed. I give permission for the school to contact my child's physician for medical instructions. In the event that I can not be reached and emergency hospital care/treatment is needed, I give my permission for my child to be taken to the nearest hospital and given the necessary care.

**X PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**CONSENT TO SHARE INFORMATION:** I give my permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

**X PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

<b>HEALTH HISTORY</b>		
Check illnesses or conditions your child has had or has and give dates:		
_____ Asthma	_____ ADD/ADHD	
_____ Diabetes	_____ Strep Throat	_____ Psychiatric Illness
_____ Seizures	_____ Chronic Ear Problems	_____ Orthopedic problems
_____ Heart Disease	_____ Hypertension	_____ Other
Significant Medical/Surgical History: _____		
ALLERGIES: <input type="checkbox"/> LIFE THREATENING _____		
MEDICATION/TREATMENT: _____		
DIETARY RESTRICTIONS: _____		
DENTIST/ORTHODONTIST: _____ PHONE: _____		

**NON-PRESCRIPTION MEDICATION PERMISSION. Both parent and physician signatures required.**

Please initial the medication(s) the school nurse may administer to your child. No medications will be given unless it is approved /initialed by a parent and signed by the student's physician. \*Medications will be administered based on child's age and weight.

- |   |  |
|---|--|
| _____ Acetaminophen (Tylenol) – 325mg tablets | _____ Ibuprofen (Motrin, Advil) -200mg tablets   |
| _____ Acetaminophen Chewable Tablets, 80mg    | _____ Ibuprofen Liquid (Motrin, Advil) 100mg/5ml |
| _____ Acetaminophen Liquid 80mg/5ml           | _____ Tums                                       |
| _____ Benadryl capsules (25mg)                | _____ Neosporin/Bacitracin topical ointment      |
| _____ Benadryl Liquid 12.5mg/5ml              | _____ Hydrocortisone 0.5% topical cream          |
| _____ Cepacol Lozenges                        | _____ First Aid burn gel topical gel             |

\_\_\_\_\_ **NO NON-PRESCRIPTION MEDICATIONS MAY BE GIVEN TO THIS STUDENT**

**X PARENT APPROVAL/SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**I give my permission for the school nurse to administer the above medications initialed by the parents**

**X PHYSICIAN SIGNATURE** \_\_\_\_\_ **PHONE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PART 2 – TO BE COMPLETED AND SIGNED BY PHYSICIAN**

DATE OF EXAM: \_\_\_\_\_

**IMMUNIZATION HISTORY DATES**

Dpt / DaP \_\_\_\_\_ Booster \_\_\_\_\_  
 OPV or IPV \_\_\_\_\_ Varicella \_\_\_\_\_  
 MMR \_\_\_\_\_ Hep B \_\_\_\_\_  
 HIB \_\_\_\_\_ Other \_\_\_\_\_  
 Mantoux PPD \_\_\_\_\_ Date Tested \_\_\_\_\_ Date Interpreted \_\_\_\_\_ Results \_\_\_\_\_

**PHYSICAL EXAM**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure \_\_\_\_\_ BODY MASS INDEX \_\_\_\_\_  
 HEENT \_\_\_\_\_ SKIN \_\_\_\_\_ Musculoskeletal \_\_\_\_\_ LUNGS \_\_\_\_\_  
 GU \_\_\_\_\_ CARDIAC \_\_\_\_\_  
 NEURO \_\_\_\_\_ GI \_\_\_\_\_ Physical Maturity (Tanner Stage): I. II. III. IV. V.  
 Dental/ Orthodontic Referral  Yes  No Date: \_\_\_\_\_

**EXAM ENTIRELY NORMAL**

**Specify any abnormality and current health problems:** \_\_\_\_\_

**Significant Past Illness, Injuries, and Operations:**

**Allergies (Food, Drug, and Environmental):**

**Screening:**

Vision: R \_\_\_\_\_ Corrected \_\_\_\_\_ Uncorrected \_\_\_\_\_ Hearing: R \_\_\_\_\_ L \_\_\_\_\_  
 L \_\_\_\_\_ Corrected \_\_\_\_\_ Uncorrected \_\_\_\_\_  
 Scoliosis:  Negative  Positive: \_\_\_\_\_ Lead (0-10) \_\_\_\_\_

**MEDICATIONS**

Prescription Medications:  None

Medication: \_\_\_\_\_ Indication: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Medication: \_\_\_\_\_ Indication: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

\_\_\_\_\_ This student **may participate** fully in school physical activities including team sports, gym, and dance classes.  
 \_\_\_\_\_ This student **may not participate** fully in school physical activities including team sports, gym and dance classes.  
 \_\_\_\_\_ OTC (Over The Counter) medications as indicated by parent in Part I may be administered as per package protocol.

**Provider's name:** \_\_\_\_\_

**Provider's stamp:**

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**X Provider's signature:** \_\_\_\_\_

**PART 3 TO BE COMPLETED BY PARENT AND STUDENT ATHLETE**

**ATHLETIC PARTICIPATION HEALTH SCREENING**

**Have you ever had an illness that:**

	Yes	No	Explain
Required a hospital stay?	<input type="radio"/>	<input type="radio"/>	_____
Caused you to miss 3 days of practice or a competition?	<input type="radio"/>	<input type="radio"/>	_____
Required an operation?	<input type="radio"/>	<input type="radio"/>	_____
Is related to allergies? (i.e. hay fever, hives, asthma, insect stings)	<input type="radio"/>	<input type="radio"/>	_____
Is chronic? (i.e.. asthma, diabetes, etc.)	<input type="radio"/>	<input type="radio"/>	_____

**Have you ever had an Injury that:**

Required you to see a doctor?	<input type="radio"/>	<input type="radio"/>	_____
Required you to go to an emergency room?	<input type="radio"/>	<input type="radio"/>	_____
Required a hospital stay?	<input type="radio"/>	<input type="radio"/>	_____
Required x-rays or an operation?	<input type="radio"/>	<input type="radio"/>	_____
Caused you to miss 3 days of practice or competition?	<input type="radio"/>	<input type="radio"/>	_____

**Have you ever:**

Been dizzy or passed out during or after exercise or participation in sports?	<input type="radio"/>	<input type="radio"/>	_____
Been unconscious, had a concussion, or seizure?	<input type="radio"/>	<input type="radio"/>	_____
Had a heart murmur, high blood pressure, or a heart abnormality?	<input type="radio"/>	<input type="radio"/>	_____

**Do you:**

Wear glasses or contacts?	<input type="radio"/>	<input type="radio"/>	_____
Wear bridges, braces, or a dental plate?	<input type="radio"/>	<input type="radio"/>	_____
Have any current physical complaints (i.e. back, neck or joint pain)?	<input type="radio"/>	<input type="radio"/>	_____

**Are you:**

Missing a kidney?	<input type="radio"/>	<input type="radio"/>	_____
Able to run _ mile without stopping?	<input type="radio"/>	<input type="radio"/>	_____
Allergic to any medications?	<input type="radio"/>	<input type="radio"/>	_____
Currently taking any medications, including inhalers?	<input type="radio"/>	<input type="radio"/>	_____

List all medications you are presently taking and the condition you are taking the medication for: \_\_\_\_\_  
\_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are correct.**

**X** Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**X** Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**In case of emergency:**

Parent/Guardian: \_\_\_\_\_ Home# \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Person to be notified in case of an emergency if unable to reach parent:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician's Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**EMERGENCY CARE AUTHORIZATION:** I give my permission for the school to administer first aid if needed. In the event that I cannot be reached and emergency hospital care/treatment is needed, I give my permission for my child to be taken to the nearest hospital and given the necessary emergency care.

**X Parent Signature:** \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Relationship \_\_\_\_\_