



**PHYSICAL EXAMINATION AND PROOF OF VACCINATION FORM**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Female  Male  
(month/day/year)

**PART II - TO BE FILLED OUT BY THE PARENT AND VERIFIED BY THE PHYSICIAN.**

<b>IMMUNIZATIONS</b>	<b>RECORD DATES AND ATTACH VACCINE RECORDS</b> NOTE: Copies of Non-English immunization records are acceptable.
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Type of Vaccinations		Date received (Month/Day/Year)				
<b>Polio</b>	<b>OPV (Oral)</b>	__/__/__ (2months)	__/__/__ (4months)	__/__/__ (6 Months)	__/__/__ (18months)	__/__/__ (age 4-6 y/o)
	<b>IPV (Inactivated)</b>	__/__/__ (2months)	__/__/__ (4months)		__/__/__ (18months)	__/__/__ (age 4-6 y/o)
<b>DTP or DTap (Diphtheria, Pertussis, Tetanus)</b>		__/__/__ (2months)	__/__/__ (4months)	__/__/__ (6 Months)	__/__/__ (18months)	__/__/__ (age 4-6 y/o)
<b>Tdap or Td (Tetanus Booster)</b>						__/__/__ (booster after age 10)
<b>MMR (Measles/Mumps/Rubella)</b>					__/__/__ (12months)	__/__/__ (age 4-6 y/o)
<b>Hepatitis B (required 3 dose)</b>		__/__/__ (at birth)	__/__/__ (2months)	__/__/__ (6 months)		

NOTE TO PHYSICIAN: ISB follows the immunization recommendation from US Center for Disease Control (CDC) guidelines.  
(Website: <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>)

IMMUNIZATION GIVEN TODAY: \_\_\_\_\_

- Up-to- date (see the attached immunization records )
- Not up-to-date/Specify \_\_\_\_\_
- Immunization record attached
- No Immunization given today

<b>Health Care Provider</b> verifying above immunization history must sign below.		
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**PART III- TO BE FILLED OUT BY PHYSICIAN / HEALTH CARE PROVIDER.**

<b>Health Assessment</b>	Date of Assessment: __/__/__  Height _____ Weight _____ Body Temperature _____ Blood Pressure __/__/__ Pulse ____ Build: <input type="checkbox"/> Slender <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Obese  For Female only: Menses __Yes __No	<b>Physical Examination</b>  1= Within Normal 2= Abnormal Finding 3= Referred for Evaluation/treatment  <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">HEENT 1 2 3</td> <td style="width: 33%;">Neurological 1 2 3</td> <td style="width: 33%;">Skin 1 2 3</td> </tr> <tr> <td>Lungs 1 2 3</td> <td>Abdomen 1 2 3</td> <td>Genital 1 2 3</td> </tr> <tr> <td>Heart 1 2 3</td> <td>Extremities 1 2 3</td> <td>Urinary 1 2 3</td> </tr> <tr> <td>Lymph nodes 1 2 3</td> <td>Back/Spine 1 2 3</td> <td></td> </tr> </table>	HEENT 1 2 3	Neurological 1 2 3	Skin 1 2 3	Lungs 1 2 3	Abdomen 1 2 3	Genital 1 2 3	Heart 1 2 3	Extremities 1 2 3	Urinary 1 2 3	Lymph nodes 1 2 3	Back/Spine 1 2 3				
HEENT 1 2 3	Neurological 1 2 3	Skin 1 2 3															
Lungs 1 2 3	Abdomen 1 2 3	Genital 1 2 3															
Heart 1 2 3	Extremities 1 2 3	Urinary 1 2 3															
Lymph nodes 1 2 3	Back/Spine 1 2 3																
<b>Hearing Screen</b>	Screened at <b>20dB</b> : Indicate Pass(P) or Refer ( R) in each box  <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>500</td> <td>1000</td> <td>2000</td> <td>4000</td> </tr> <tr> <td>Right</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <input type="checkbox"/> Pass <input type="checkbox"/> Refer		500	1000	2000	4000	Right					Left					<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Permanent Hearing Loss Previously identified ___Right ___Left <input type="checkbox"/> Hearing aid or other assistive device <input type="checkbox"/> Unable to test – needs rescreening
	500	1000	2000	4000													
Right																	
Left																	



### Vision Screening

With Corrective Lenses ( check if YES)

Stereopsis __ Pass __ Fail			<input type="checkbox"/> Not tested	
Distance	Both Eyes	Right Eye	Left Eye	Test used:
	20/	20/	20/	

\_\_ Pass \_\_ Referred to eye doctor

\_\_ Unable to test – needs rescreening

### TB SCREENING

No Risk for TB infection identified. TB test is not necessary.  
BCG Received; Yes  No

Risk for TB infection or suspected TB symptoms. This child is recommended to take TB test.

#### PPD/ Mantoux Test/ IGRA T-spot

Date \_\_\_/\_\_\_/\_\_\_ Result :  Positive  Negative ( TST Reading \_\_\_ mm )

Or

**Chest X-Ray** (required if PPD or Interferon positive)

Date: \_\_\_/\_\_\_/\_\_\_  Normal  Abnormal

### MEDICAL ASSESSMENT

Attach another page if more space needed if you want to add more information.

<p><b>Infectious Disease</b></p> <p><input type="checkbox"/> Chicken Pox <input type="checkbox"/> Infectious Mononucleosis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis</p> <p><b>Eyes, Ears, Nose, Throat</b></p> <p><input type="checkbox"/> Wear glasses/contact <input type="checkbox"/> Other Visual Problems <input type="checkbox"/> Hearing Loss/Deafness <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Recurrent Sinus Infection <input type="checkbox"/> Recurrent Ear Infection <input type="checkbox"/> Recurrent Nose Bleeds</p> <p><b>Cardiopulmonary</b></p> <p><input type="checkbox"/> Chest pain with exercise or exertion <input type="checkbox"/> Syncope or Near Syncope <input type="checkbox"/> Excessive exertional or unexplained shortness of breath with exercise <input type="checkbox"/> Excessive exertional or unexplained fatigue with exercise <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Elevated Blood Pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Heart Palpitations or Irregular beat <input type="checkbox"/> Marfan Syndrome <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia/Bronchitis</p>	<p><b>G-I</b></p> <p><input type="checkbox"/> Reflux/GERD <input type="checkbox"/> Ulcer <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Hepatitis Type: ____ <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Crohn's Diseases <input type="checkbox"/> Ulcerative Colitis</p> <p><b>Genitourinary</b></p> <p><input type="checkbox"/> Cystitis/Bladder Infection <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Kidney Stones</p> <p><b>Female</b></p> <p><input type="checkbox"/> Severe cramps <input type="checkbox"/> Irregular periods <input type="checkbox"/> Heavy flow <input type="checkbox"/> Ovarian Cyst</p> <p><b>Male</b></p> <p><input type="checkbox"/> Testicular Lump <input type="checkbox"/> Testicular Torsion <input type="checkbox"/> Undescended /absent testicle</p> <p><b>Skin</b></p> <p><input type="checkbox"/> Eczema <input type="checkbox"/> Acne <input type="checkbox"/> Hives <input type="checkbox"/> Chronic rash <input type="checkbox"/> Tattoos/Piercings <input type="checkbox"/> Others _____</p>	<p><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Injury <input type="checkbox"/> Bone fractures <input type="checkbox"/> Scoliosis <input type="checkbox"/> Back Pain/Problems <input type="checkbox"/> Osgood – Schlatter <input type="checkbox"/> Tendinitis <input type="checkbox"/> Other Musculoskeletal Disorders</p> <p><b>Hematologic /Oncologic</b></p> <p><input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell trait/disease <input type="checkbox"/> Leukemia/Lymphoma <input type="checkbox"/> Hemophilia <input type="checkbox"/> Immune Deficiency</p> <p><b>Neurologic</b></p> <p><input type="checkbox"/> ADD /ADHD <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Tension Headaches <input type="checkbox"/> Concussion <input type="checkbox"/> Head Injury with loss of Consciousness <input type="checkbox"/> Other Neurological Disorders</p> <p><b>Mental/ Emotional</b></p> <p><input type="checkbox"/> Anger Management <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Obsessive Compulsive Disorders <input type="checkbox"/> Depression <input type="checkbox"/> Other: _____</p>	<p><b>Metabolic</b></p> <p><input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Thyroid Disorder</p> <p><b>Other</b></p> <p><input type="checkbox"/> Anaphylactic Reaction <input type="checkbox"/> Serious Injury</p> <p><b>Medications</b> (Is this student taking any medication on a regular basis?)</p> <p>_____</p> <p>_____</p> <p><b>Other Medical Information</b> (Use this space to provide any additional information.)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>* If more space required Please use other page.</b></p>
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**\*CHRONIC DISEASE ASSESSMENT:**

<b>Asthma</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced  <input type="checkbox"/> <b>If YES, please provide a copy of the ASTHMA ACTION PLAN to School.</b>
<b>Allergies</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Medication <input type="checkbox"/> Unknown Source  History of Anaphylaxis <input type="checkbox"/> No <input type="checkbox"/> Yes Epi-Pen required <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> <b>If YES, please provide a copy of the FOOD ALLERGY ACTION PLAN to School.</b>
<b>Diabetes</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> <b>If YES, please provide a copy of the DIABETES ACTION PLAN to School.</b>
<b>Seizures</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> <b>If YES, please provide a copy of the SEIZURE ACTION PLAN to School.</b>
<b>Other Chronic Disease:</b>	

**CLEARANCE: This section is completed by the examining healthcare provider.**

After examining the student and reviewing the medical history the student is:

- A. Cleared** for participation of **all** sports without restrictions.
  - B. Not cleared** for participation in **any** sport until evaluation/treatment of:  
\_\_\_\_\_
  - C. Cleared for limited participation** in the following types of sports only.  
\_\_\_\_\_
- Limitation due to: \_\_\_\_\_

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Physician's/ Provider's Stamp:

Physician's Signature \_\_\_\_\_



Today's Date \_\_\_\_\_

Date of Exam: \_\_\_\_\_