WILBRAHAM & MONSON ACADEMY 2020-2021
423 Main Street, Wilbraham, Massachusetts 01095 Phone 413.596.6811 Fax 413.596.3655 website: www.wma.us

PHYSICAL EXAM FORM

Print this form and bring it to* your child's *physician to complete

Name _____ Date of Birth _____ (mm/dd/yy) Date of Exam _____ (mm/dd/yy)

To the examining Health Care Provider: Please correlate the student's medical history with your findings and record below. All entries must be completed.

Gender _____ Height_____ Weight _____ BP_____ Pulse _____

Vision: Right 20/ _____ Left 20/ _____

Vision with correction: Right 20/ _____ Left 20/ _____

	Normal	Abnormal	Details
Ears/Hearing, Nose, Throat			
Mouth, Teeth, Orthodontics			
Eyes – general			
Lungs, Chest, Breasts			
Heart/Vascular			
Gastrointestinal, Nutritional			
Endocrine (Diabetes)			
Genital – Urinary (hx. UTI)			
Spine, Scoliosis, Musculoskeletal			
Skin			
Neurological			
Psychiatric			
Menstrual Cycle history: Specify medication or problems			

Dental or eye care needed:_____

Is this student capable of normal physical activity? _____

If not, give reasons and limitations:_____

_____

ALLERGIES: _____

Is student taking any **medication?** _____

If so, for what purpose?_____

_____

Signature of examining Health Care Provider: _____

Address:_____

Date: _____ Telephone Number:_____

IMMUNIZATIONS 2020-2021

Student:_____ Date of Birth_____
First Name Middle Last Name mm/dd/yy

Required Vaccine	Dates Given	MA State Requirements
MMR	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____**MANDATORY**	2 doses **OR** positive titers Minimum of 4 weeks between doses 1st dose given after 1st birthday
Measles	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____	
Mumps	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____	Option of combined MMR **OR** individual vaccines
Rubella	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____	
DTaP/DTP/Td	#1 ____/____/___ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____**MANDATORY**	5 doses mandatory for school entry. One dose for all students entering grade 7. Boosters every 10 years.
Tdap	#1 ____/____/____ **MANDATORY**	
Polio (IPV/OPV)	#1 ____/____/___ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____**MANDATORY**	4 doses mandatory for school entry. If 4 doses are given before age 4, then a 5th dose is required.
Menveo or Menactra	#1 ____/____/____ **OR** #2 ____/____/____	Grade 7: 1 does for all students Grade 11: 1 booster dose on or after age 16
Varicella	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer Date ____/____/____ **MANDATORY** **OR** History of disease: Date ____/____/____	2 doses varicella OR positive titer **OR** history of disease. Minimum of 4 weeks between doses if age 13 or older
Hepatitis B	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ **OR** Positive Titer HBs Ab Date: ____/____/____ MANDATORY	3 doses **OR** positive titer Minimum 4 weeks between doses 1 and 2 Minimum 3 months between doses 2 and 3
Hepatitis A	#1 ____/____/____ #2 ____/____/____	Hepatitis A is recommended
Guardasil/Cervarix	#1 ____/____/___ #2 ____/____/____ #3 ____/____/____	Recommended vaccine
Meningococcal B	#1 ____/____/____	Recommended vaccine

Tuberculosis Risk Assessment - Required for ALL students

To the best of your knowledge, have you had close contact with anyone who was sick with Tuberculosis .....Yes ☐ No ☐

Were you born in a country with high rates of TB (most Asian, African and South American countries) .....Yes ☐ No ☐

Have you traveled or lived more than a month in one of the countries with a high rate of TB? .....Yes ☐ No ☐

A history of BaccilleCalmette-Guerin (BCG) vaccination does not remove the requirement.

If a student has had a positive PPD in the past, and has not been treated for latent TB, a chest x-ray is required.

If a student has been treated for latent TB, no further testing is required but the treatment must be documented below.

Treatment for positive PPD? Yes ☐No ☐If yes, describe: _____

If you answered YES to any of the above questions, either PPD test (also known as Mantoux) OR Interferon Gamma Release Assay (IGRA) test must be completed within 4 months prior to entering the USA.

PPD (Mantoux) Test: *(Tine, Monova or Heaf tests are not acceptable replacement for Mantoux)*

Date read:_____(MM/DD/YY) **Results:** _____(actual mm or induration, transverse diameter)

IGRA: Positive☐ Negative☐ Indeterminate☐ Date: _____

Chest X-ray (If PPD is positive or IGRA is positive or indeterminate*)* **Results:** Normal ☐Abnormal ☐ Date:_____

Physician Name _____
Print *Signature* *Date*

Phone _____ Fax_____ email_____