

Hawthorn School District 73

841 West End Court, Vernon Hills, Illinois 60061

Phone (847) 990-4200 / Fax (847) 367-3290

www.hawthorn73.org

El Estado de Illinois requiere que nuestras escuelas mantenga expedientes con documentos relacionados a la salud de su hijo/a. **La ley estatal requiere que los estudiantes que no tienen los documentos apropiados en los archivos dentro de 30 días o para el 15 de Octubre serán excluidos de la escuela.** La mayoría de las formas requieren la firma de un medico y los padres. Por favor, mantenga copias de todos los expedientes de sus propios archivos. Los formularios también los puede descargar en www.hawthorn.73.org/health

Estudiantes que entraran a una escuela de Illinois por primera vez:

- Certificado de Examen de Salud del niño/a (por favor de completar ambos lados o se considerara incompleto)
- Reporte del Examen de Visión
- Comprobante del Examen Dental Escolar

* Si esta interesado en participar en atletismo extracurricular en las Escuelas Middle:

- IHSA/IESA Examen del Atlético (para los estudiantes que participan en el atletismo de la escuela media)

Estudiantes transfiriéndose de otra escuela publica en Illinois:

- Certificado de Examen de Salud del niño/a (por favor de completar ambos lados o se considerara incompleto)

Si entraran al Kindergarten:

- Reporte del Examen de Visión

Si entraran al Kindergarten, 2o grado o 6o grado:

- Comprobante del Examen Dental Escolar

* Si esta interesado en participar en atletismo extracurricular en las Escuelas Middle:

- IHSA/IESA Examen del Atlético (para los estudiantes que participan en el atletismo de la escuela media)

Estudiantes que entraran al Kindergarten:

- Certificado de Examen de Salud del niño/a (por favor de completar ambos lados o se considerara incompleto)
- Cuestionario de Asesoramiento Infantil a Riesgo por el Plomo
- Reporte del Examen de Visión
- Comprobante del Examen Dental Escolar

Estudiantes que continuarán con Hawthorn deberán proporcionar:

Si entraran al 2o grado o 6o grado:

- Comprobante del Examen Dental Escolar

Si entraran al 6o grado:

- Certificado de Examen de Salud del niño/a (por favor de completar ambos lados o se considerara incompleto)
- Prueba de la vacuna Tdap
- Prueba de una vacuna conjugada meningocócica (MCV4) administrada en o después de su 11º cumpleaños

* Si esta interesado en participar en atletismo extracurricular en las Escuelas Middle:

- IHSA/IESA Examen del Atlético o Certificado de IL de salud de infantil (para los estudiantes que participan en el atletismo de la escuela media)

Estudiantes con problemas de salud específicos también deben informar a la enfermera de la escuela y completar los formularios de salud adecuados. Una variedad de formularios están disponibles en www.hawthorn73.org/health. Para obtener mas información o asistencia, por favor llame a la enfermera de su escuela.

Enfermeras de las Escuelas Hawthorn:

Elementary North: Lisa Frazier-Sweeny 847-990-4514

Elementary South: Francie Mundrane, 847-990-4815

Aspen Elementary: Caitlin Natsch, 847-990-4314

Townline Elementary: Dena Mahrenholz, 847-990-4915

School of Dual Language: Megan Copeland, 847-990-4914

Hawthorn Middle North: Janet Howard, 847-990-4415

Hawthorn Middle South: Lora Jacobs, 847-990-4118

Lincoln School: Deb Geib, 847-949-2720



**State of Illinois
Certificate of Child Health Examination**

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian	Telephone # Home		Work
Street			City	Zip Code		

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
 Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one) Measles* Mumps Rubella Varicella Attach copy of lab result.**
 *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
 **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
 Physician Statements of Immunity MUST be submitted to IDPH for review.

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.
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HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)	<input type="checkbox"/> Sí <input type="checkbox"/> No	Anótelas todas:	MEDICINAS (Anote todas las recetas o tomadas con regularidad)	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene diagnóstico de asthma? ¿Despierta el niño tosiendo en la noche?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene defectos de nacimiento?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene retrasos del desarrollo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido heridas graves o enfermedades?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene diabetes?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Prueba positiva de TB (Pasado o Presente)?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene heridas en la cabeza/golpe/desmayo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Enfermedad de TB (Pasado o Presente)?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene convulsiones? Cómo se manifiestan?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Usa tabaco (tipo, frecuencia)?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene problemas cardiacos/No respira bien?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Toma alcohol/drogas?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene soplo en el corazón/presión arterial alta?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	<input type="checkbox"/> Sí <input type="checkbox"/> No
¿Tiene mareos o dolor de pecho al hacer ejercicios?	<input type="checkbox"/> Sí <input type="checkbox"/> No		Dental <input type="checkbox"/> Ganchos <input type="checkbox"/> Puente <input type="checkbox"/> Placas <input type="checkbox"/> Otro	
¿Problemas con los ojos/visión? <input type="checkbox"/> Lentes <input type="checkbox"/> Lentes de Contacto <input type="checkbox"/> Último examen <input type="checkbox"/> ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.	
¿Tiene problemas de los oídos/no oye bien?	<input type="checkbox"/> Sí <input type="checkbox"/> No		Firma del Padre/Tutor	Fecha
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	<input type="checkbox"/> Sí <input type="checkbox"/> No			

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if <2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes No And any two of the following: **Family History** Yes No
Ethnic Minority Yes No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No **At Risk** Yes No

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm

No test needed **Test performed** **Skin Test: Date Read** / / **Result: Positive** **Negative** **mm** _____
Blood Test: Date Reported / / **Result: Positive** **Negative** **Value**

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears		Screening Result:	Gastrointestinal	
Eyes		Screening Result:	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	

Currently Prescribed Asthma Medication:
 Quick-relief medication (e.g. Short Acting Beta Agonist)
 Controller medication (e.g. inhaled corticosteroid)

NEEDS/MODIFICATIONS required in the school setting **DIETARY** Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
 If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes **No** If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** Yes No Modified

Print Name _____ (MD,DO, APN, PA) **Signature** _____ **Date** _____

Address _____ **Phone** _____



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: Normal or Positive for _____

Medical history: Normal or Positive for _____

Drug allergies: NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective lenses: No Yes, glasses or contacts should be worn for:
 Constant wear Near vision Far vision
 May be removed for physical education

2. Preferential seating recommended: No Yes

Comments _____

3. Recommend re-examination: 3 months 6 months 12 months
 Other _____

4. _____

5. _____

Print name _____

License Number _____

Optometrist or physician (such as an ophthalmologist)
 who provided the eye examination MD OD DO

Address _____

Phone _____

Signature _____

Date _____

<p>Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p>_____</p> <p style="text-align: center;">(Parent or Guardian's Signature)</p> <p>_____</p> <p style="text-align: center;">(Date)</p>
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(Source: Amended at 32 Ill. Reg. _____, effective _____)



FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

Para ser completado por el padre/madre (por favor impresión):

Nombre del Estudiante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: / / (Mes/Día/Año)
Dirección:	Calle	Ciudad	Código Postal	Número de Teléfono:
Nombre de la Escuela:	Grado:		Sexo: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino	
Nombre del padre/madre o encargado:			Dirección del padre/madre o encargado:	

To be completed by dentist: (Para ser completado por el dentista:)

Oral Health Status (check all that apply)

Yes No **Dental Sealants Present**

Yes No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

Yes No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

Yes No **Soft Tissue Pathology**

Yes No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care — amalgams, composites, crowns, etc.

Preventive Care — sealants, fluoride treatment, prophylaxis

Other — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date of Exam _____

Address _____
Street City ZIP Code

Telephone _____





Pre-participation Examination



To be completed by athlete or parent prior to examination.

Name _____ School Year _____
Last First Middle

Address _____ City/State _____

Phone No. _____ Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Phone No. _____

Address _____ City/State _____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____



Pre-participation Examination



PHYSICAL EXAMINATION FORM

Name _____
Last First Middle

EXAMINATION		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP / (/)	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

Physician's Signature _____ Physician's Name _____

Physician's Assistant Signature* _____ PA's Name _____

Advanced Nurse Practitioner's Signature* _____ ANP's Name _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.