WARDLAW + HARTRIDGE

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ANNUAL MEDICAL EXAMINATION FORM 20 - 20

- Complete and submit this form to the school nurse **only** if your child is in grades PK-4 **or** is not participating in any team sports in grades 5-12.
- If your child is in grades 5-12 and intends to participate in a sport, please complete and submit the Preparticipation Physical Evaluation (PPE) Form instead of this form.

Student Name _____

Date of Birth_____ **Grade** _____ **Male**____ **Female**_____

Has your child had any of the following? Please check the appropriate box.
If yes, please give dates/ details on line provided.

Conditions/concerns:	No	Yes	Details:
Concerns w/kidneys/urinary			
Asthma/inhaler/breathing trouble, pain w/breathing			
Headaches/migraines – specify treatment			
Diabetes/metabolic disorder - specify disease			
Joint problems/fractures/dislocation - specify			
Neurological (i.e. ADD) /seizure - please specify			
Orthopedic/spinal concerns/back/neck			
Heart/Cardiac problems - specify (i.e. palpitations, pain)			
Head injury/concussion/loss of consciousness			
Fainting; fainting related to exercise/exercise related problems			
Vision problems-glasses contacts (circle, specify)			
Hearing difficulties/ear infections			
Experiencing fatigue or tiredness			
Any surgery/surgeries			
Other not listed above_____			
Is your child under medical care now? If yes, please comment			
Has your child been told by a medical professional not to participate in sports/gym/school/camp?			
Is there a history of sudden death in the family?			
Psychiatric diagnosis/emotional problems/stress/anxiety			
Any allergies: _____ Does your child carry/have an epinephrine-pen? __yes or__ no			

Parent Consent: *I authorize Wardlaw-Hartridge School personnel, administrators, nurse(s), ch.226 nurse/s to share confidential medical information on a need to know basis, with appropriate Wardlaw-Hartridge employees (and affiliated agencies, like food services). I understand that sharing of medical information is to help promote the health and safety of my child. I authorize the school nurse(s), and employees of Wardlaw-Hartridge School to perform first aid, screenings, illness and emergency care for my child, as deemed necessary. Parent authorizes school nurse to contact MD if needed. A parent can refuse non-emergency nurse screenings by stating so in writing to nurse. All medications given/taken during school hours require a written doctor's order and written parental consent in order for the nurse to administer or for the student to self-administer. See school nurse for forms. Parent/s and Guardian/s are advised to keep school nurse current with updates on medical issues or changes.*

Parent/Guardian Signature: _____ **Date:** _____

Student's Signature (required 18 & over)_____ **Date:** _____

Student Name: _____

PART 2 – IMMUNIZATION all students must have a current immunization list attached

Part 3 – MEDICAL EXAMINATION by private/primary MD, DO, APN
(To be completed and signed by Examining Health Professional - **not to be filled in by parent)**

Date of Examination: _____HR:_____RR:_____BP:_____

Height: _____Weight: _____ BMI:_____ Percentage:_____

Scoliosis: No or Yes, explain: _____

Allergies: No or Yes, list: _____ Epi-pen: Yes or No

Medical Conditions / Chronic illnesses: _____

Surgical History or injuries: _____

General or exercise related conditions: _____

Medications taken/prescribed: _____

Examination of: Please comment if any conditions exist.	Normal (check)	Abnormal-please note Or use space for Comments
Vision: Eyes, Sclera, (circle if) Contact lenses, glasses, or both		
Ears: Otoscopic, Hearing, Eardrum If infections – perforation or hearing loss		
Skin: Infections, scars, traumas, jaundice, or purpura		
Head: Nose, Mouth, Teeth, list conditions of the head		
Neck:: Thyroid, Throat**,** Mobility		
Cardiac: Rate & Rhythm**,** Murmurs (absent or present) Heart related conditions		
Pulmonary: Lung sounds, Chest Contour, Percussion		
GI Abdomen: Liver, Spleen **Masses:** (circle) yes or no Hernia: (circle) yes or no		
GU Kidney: If male testes: normal or abnormal		
Orthopedic: Skeletal, Spine, Joints, ROM, any orthopedic conditions		
Musculature: Coordination, Extremities, Strength		
Neurological: Balance, Gait, Cranial Nerves		
Condition of Extremities:		
Physiological Maturation:		

I, _____ (please **print** health professional's name)**,** have reviewed the parent questionnaire, reviewed this student's health history and performed a thorough physical exam. It is my professional judgment that this student * in all aspects of school/sports/gym/camp, including full contact sports.

* **Check one:** ☐ **<u>can</u> participate fully** ☐ **is <u>not allowed</u> to participate**

☐ **<u>limited</u> in activity and specify:** _____

Please specify if student requires clearance by a specialist: _____

Examing Health Professional's Signature_____Date_____

Provider's Stamp:
include name, address and phone number