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Medical Examination Form

Complete and submit this form to the school nurse **only** if your child is in grades PK-5 or is **not** participating in any team sports in grades 6-12.
If your child is in grades 6-12 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 _____

Part 1: Parent Questionnaire

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

Condition/Concern	Yes	No	Details
Concerns with kidney / Urinary			
Asthma/Inhaler / breathing trouble / pain with breathing			
Headaches / Migraines (specify treatment)			
Diabetes / Metabolic Disorder (specify disease)			
Joint problems / fractures / dislocation (specify)			
Neurological (i.e. ADD) / Seizures (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 (specify)			
Hearing difficulties / ear infections			

Student Name: _____

Condition/Concern	Yes	No	Details
Experiencing fatigue / tiredness			
Any Surgery / surgeries			
Psychiatric diagnosis / emotional problems/ stress / anxiety			
Any Allergies			
Does your child carry or have an Epi pen?			

Any other concerns not listed above: Yes or No (please circle) _____

Is your child under medical care now? If yes, please comment below.

_____

Has your child been told by a medical professional not to participate in sports/gym/school/camp? Yes or No (please circle)

Is there a history of sudden death in the family? Yes or No (please circle)

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 the school nurse to contact MD if needed. A parent can refuse non-emergency nurse screenings by stating so in writing to the 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 Signature (18 & over): _____ **Date:** _____

Part 2:
Immunization: Special note for students in grades *PreK, JK, K, 1st, 6th, and any new students, an updated immunization record must be attached.*

Student Name: _____

Part 3:
Medical Examination by private /primary MD, DO, APN.
This section is to be completed and signed by an examining health professional, not parent/guardian.

Date of Examination: _____HR:_____RR:_____BP:_____
Height:_____Weight: _____ BMI:_____ Percentage:_____
Hearing right _____ Hearing left_____
Vision right_____ Vison left _____ corrected, Yes or No (please circle)
Scoliosis: Yes or No (please circle)
Explain: _____

Allergies: Yes or No (please circle) if yes please list: _____
Epi-pen: Yes or No (please circle)

Medical Conditions / Chronic Illnesses:

_____

Surgical History or injuries:

_____

General or exercise related conditions:

_____

Medications prescribed/taken:

_____

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		
GU Kidney: If male testes: normal or abnormal		
Orthopedic: Skeletal, Spine, Joints, ROM, any orthopedic conditions		
Musculature: Coordination, Extremities, Strength		

Student Name: _____

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
(Check one)

_____ can participate fully,
_____ is not allowed to participate, or
_____ is limited in activity

in all aspects of school/sports/gym/camp, including full contact sports.

If limited please specify: _____ .

Please specify if student requires clearance by a specialist:

_____ .

Examining Health Professional's Signature:

_____ Date_____

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

Office Stamp: