EVERY STUDENT **MUST** HAVE A CURRENT (WITHIN ONE YEAR) PHYSICAL EXAM TO ATTEND DOANE ACADEMY.

**\*\*\*** THIS FORM MUST BE RETURNED PRIOR TO THE START OF THE SCHOOL YEAR FOR NEW STUDENTS and RETURNING STUDENTS WITH PHYSICALS COMPLETED JUNE THROUGH AUGUST.

**\*\*\*** FOR RETURNING STUDENTS WITH PHYSICALS COMPLETED DURING THE SCHOOL YEAR, FORMS MUST BE RETURNED WITHIN ONE WEEK OF PHYSICIAN’S VISIT.

**TO BE COMPLETED BY PARENT:**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2018-2019 Grade level: \_\_\_\_\_\_\_\_\_\_\_\_\_                        Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should an emergency arise, I authorize the school or its representatives to secure such assistance as may be required such as first aid or emergency treatment.  I also authorize the nurse to share medical information that pertains to the well-being of my student to faculty and/or staff.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  \_\_\_\_\_\_\_

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**TO BE COMPLETED BY PHYSICIAN:**

(A)   Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                                   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

       Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                                   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

       Other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student require an EPIPEN, an inhaler or any other medication?    Yes\_\_\_\_ No\_\_\_\_

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can student self-carry? Yes\_\_\_ No \_\_\_

(B)   List any history of serious/chronic illness, injury, surgeries or mental health issues.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(C)   Physical Exam (**must be completed in full):**

    Height: \_\_\_\_\_\_\_\_      Weight: \_\_\_\_\_\_lbs     BP: \_\_\_\_\_\_\_\_     Heart Rate: \_\_\_\_\_\_

    BMI #/%: \_\_\_\_\_\_\_\_      BMI within recommended range? \_\_\_\_\_\_\_\_ (Y/N)

Was counseling or follow up initiated? \_\_\_\_\_\_\_\_\_ (Y/N)

 Scoliosis: \_\_\_\_\_\_(Y/N)     If present - Intervention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

    Hearing: R \_\_\_\_\_   L \_\_\_\_\_   (pass/fail)      Referral: \_\_\_\_\_\_\_ (Y/N)

    Vision: R\_\_\_\_\_    L\_\_\_\_ OU\_\_\_\_ Glasses/Contacts: \_\_\_\_ (Y/N) Referral: \_\_\_\_ (Y/N)

General appearance \_\_\_\_\_     Head/Neck \_\_\_\_\_     Eyes \_\_\_\_\_\_\_\_    Nose/Mouth \_\_\_\_\_

Teeth \_\_\_\_\_\_      Heart \_\_\_\_\_\_      Lungs \_\_\_\_\_\_     Skin \_\_\_\_\_\_      Abdomen \_\_\_\_\_\_    Musculoskeletal \_\_\_\_\_\_\_      Neurologic \_\_\_\_\_\_\_      GU \_\_\_\_\_\_\_      Other \_\_\_\_\_\_\_\_

Comments/Abnormal findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(D)   Current Medications:                    Reason for taking medication:

        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(E)   Clearances:

       \_\_\_\_\_ Student is cleared for **ALL** sports/gym without restrictions.

       \_\_\_\_\_ Student is **NOT** cleared for sports until evaluation/ treatment of:

              \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

       \_\_\_\_\_ Student is cleared for **LIMITED** participation.

               Limits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                       Due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(F)   Student may have the following over the counter drugs with parental consent:

Acetoaminophen, Ibuprophen, Naproxen Sodium, Calcium Carbonate (Tums), Visine (allergy relief), & throat/cough drops.  {Dosage age/weight appropriate}

 Initial: \_\_\_\_\_\_\_\_\_

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Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(G)   Immunizations received this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*    PLEASE attach immunization record to       \*\*\*\*\***

**this completed form.**

History reviewed and student examined by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Physician’s / Provider’s Signature)                    (Date of Exam)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Physician’s / Provider’s Name)                    (Today’s date if different than exam date)

Physician’s / Provider’s Stamp or Address and Phone #

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