Grace International School PHYSICAL EXAMINATION FORM

Must be completed for admission and re-enrollment.

Student's Name (Please Print):_______________________________________
Entering Grade:_______ Age:______ Date Of Birth: _____/_____/_____
MONTH DAY YEAR

To be completed by healthcare professional:

Height:_____ Weight:_____ BP:____/_____ Resting Pulse:_____ Respiration:_____ Temp:_____
Vision: R 20/____ L 20/____ Glasses: Y/N

AREA	COMMENTS	INITIALS	AREA	COMMENTS	INITIALS
HENT Head & Scalp Eyes, Ears, Nose Mouth/gums/Throat Tonsils & Adenoids Thyroid			**Musculoskeletal** Spine: Posture Shoulders Lower arm hand & fingers Knees, ankles, feet		
Chest/Lungs			**Skin** Rash, moles, scars Eczema		
Cardiovascular Heart Rate Rhythm Murmurs			**Central Nervous System** Pupil Response Reflexes Coordination		
Abdomen Tenderness or Masses Hernia Organs			**Other issues or COMMENTS:**		

CLEARANCE: <u>THIS SECTION MUST BE COMPLETED, SIGNED, AND STAMPED BY THE ATTENDING PRACTITIONER</u>

Cleared for full activity in PE class activities: Yes____ No____ Cleared for ALL sport competition Yes____ No____
If no, explain:____

<u>TB Surveillance to be completed by physician</u>

GIS requires TB skin test for all new GIS and ESD students. The chest x-ray or QFT is required for who had history of positive TB skin test reaction. TB skin test or chest x-ray or QFT are required every 3 years for re-enrollment.

Contact with potential/known TB contacts:____
(List countries or areas of high TB prevalence visited; frequent visits to refugee camps, prisons)

Cough lasting > 2 weeks? **Y / N** Unexplained weight loss? **Y / N**
Unexplained fatigue? **Y / N** HIV status? **Pos / Neg / Unknown**

Date of last TB skin test: ________________________________ Results: _______ Induration _________mm
(TB skin test required on admission, and every 3 years).
Recommendations for treatment or follow up:____
If the TB skin test is positive, a chest x-ray or QFT is required. CXR: __________________QFT:______________________

PRINTED NAME OF PRACTITIONER: ____

SIGNATURE OF PRACTITIONER: ____ **DATE OF EXAM:** __________

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HEALTH HISTORY QUESTIONNAIRE

To be completed by Parent and reviewed by Physician

1) Have you had or do you have: Family Member

			Family Member
Diabetes	**Yes**	**No**	▢
Allergies	**Yes**	**No**	▢
Migraines	**Yes**	**No**	▢
Heart Trouble	**Yes**	**No**	▢
High Blood Pressure	**Yes**	**No**	▢
Neurological Disorder	**Yes**	**No**	▢

If Yes, to any of the above please explain:________________
____

2) Have you had or do you have:
- Closed Head Injury **Yes** **No**
- Concussion **Yes** **No**
- Skull Fracture **Yes** **No**
- Seizures **Yes** **No**

3) Have you had or do you have:
- Temporary Loss of Vision **Yes** **No**
- Impaired Vision in One Eye **Yes** **No**
- Wear Contacts or Glasses **Yes** **No**

4) Have you had or do you have:
- Articulation (speech) problems **Yes** **No**
- Hearing Loss **Yes** **No**
- Perforated Ear Drum **Yes** **No**
- Recurrent Ear Infections **Yes** **No**
- Broken Nose **Yes** **No**
- Braces **Yes** **No**
- Pneumonia **Yes** **No**
- Mononucleosis **Yes** **No**
- Hepatitis **Yes** **No**

5) Have you had or do you have:
- Hernia **Yes** **No**
- Blood in Urine **Yes** **No**
- Urinary or Bowel Problem **Yes** **No**
- GI Problems **Yes** **No**

6) Have you ever had surgery? **Yes** **No**
If yes, Why?____

7) Have you ever sought professional counseling: **Yes** **No**
Eating Disorders ____ Depression_____ Addictions____
Other Emotional Issues____________________________

8) Do you have a learning disability? **Yes** **No**
Have you been diagnosed with ADD/ADHD **Yes** **No**
Takes medication: ________________________________
(Name of drug, dose and frequency)

9) Have you had or do you have:
- Foot Problems **Yes** **No**
- Shoulder Injury **Yes** **No**
- Osgood-Schlatter disease **Yes** **No**
- Bone Infection **Yes** **No**
- Back Injury or Frequent Backaches **Yes** **No**
- Knee Injury or Recurrent Pain **Yes** **No**
- Ankle Injury or Recurrent Pain **Yes** **No**
- Other Joint Problems **Yes** **No**
- Muscle Disorder **Yes** **No**

10) Have you had or do you have:
- Heart Trouble or Murmur **Yes** **No**
- High Blood Pressure **Yes** **No**
- Shortness of Breath **Yes** **No**
- Persistent Cough **Yes** **No**
- Chest Pain With Exercise **Yes** **No**
- Dizziness or tendency to faint **Yes** **No**
- Anxiety/Panic Attacks **Yes** **No**
- Anemia **Yes** **No**

If yes to any, please explain: ___________________________
____
____

11) Have you had or do you have **asthma**? **Yes** **No**
If yes, do you use any inhaler? **Yes** **No**

12) Do you have any Allergies?

Animals:	**Yes**	**No**	Epi-Pen Required	▢
Environment:	**Yes**	**No**	Epi-Pen Required	▢
Medicine:	**Yes**	**No**	Epi-Pen Required	▢
Food:	**Yes**	**No**	Epi-Pen Required	▢
Bee Sting	**Yes**	**No**	Epi-Pen Required	▢

If yes, list name(s) of Allergy, reaction and treatment used:
____
____

13) Do you take medication regularly? **Yes** **No**
If yes, specify: ____________________________________
____
(Name of drug, dose and frequency)

14) Have you had active or latent TB? **Yes** **No**
If yes, please explain, give date when diagnosed and when treatment completed____
____

If you answered "yes" to any of the above, please explain
____
____

By signing this form, you **authorize** the GIS health office to treat any minor discomfort and give over the counter medications as needed (ex Tylenol/paracetamol, Ibuprofen or antacids etc will be given orally.) Benadryl will be given in case of an allergic reaction. If you do not consent to give permission to the GIS to treat your child, please state your concern: ____

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND COMPLETE:

Signature of parent ____ Date____________________

11/20/ 2015 GIS Health Office ONLY Nurse: ______________________________ Date___________ Cleared Y/N RenWeb ▢