MEDICAL FORM 2 MED-2

PHYSICAL EXAMINATIONS FOR

- **ALL NEW STUDENTS**
- **ALL ENTERING TENTH GRADE**
- **ALL STUDENTS PLAYING SPORTS**

Four Rivers Charter Public School

Dear Parent/Guardian:

The Laws of the Commonwealth of Massachusetts require that all school-aged children must have a physical examination at specific times during their school years. At Four Rivers Charter Public School these examinations are **required in grades 7 and 10, and for any students who are new to the school.**

Students who play sports are also required to have a physical exam each year before they can participate. Sports physicals are valid for 13 months.

Student _____ Grade _____

If your child will not have had a physical within a year prior to the first day of school on August 28, 2017, please contact your child's physician to arrange to have one done this summer. If your child has already had a physical exam, please have your pediatrician fill out the attached physical examination form and return it to the school nurse. *(Note: the physician may use their own form instead of the school form if it includes all the requested information).* All students entering **grade 7** must have 2 doses of Varicella Vaccine or documented disease and 1 dose of Tdap.

Thank you for your cooperation. If you have any questions, please feel free to call me.

Jeanne Milton, RN
School Nurse
413-775-4577

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Please **check** the appropriate statement below and **return it to me in the School Nurse's Office as soon as possible**, so that I know what arrangements have been made for your child:

_____ My child has already had a physical examination done by:
Name of Physician _____ Date performed _____
(Please attach a copy of the examination record.)

_____ My child is scheduled for a physical examination to be done by:
Name of Physician _____ Date to be performed _____
(A copy of the examination record should be sent to the school nurse.)

_____ _____
Parent/Guardian Signature *Date*

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____

Medical History _____

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____(____%) Wgt: _____(____%) BMI: _____(____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate/Borderline
Referred for evaluation to: _____ Date: _____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*