☐ Forwarded to School Nurse/RN for review

Pierce County

HEALTH REPORT

TIME OF EXAMINATION: For athletics, exams must be given during the 24-month period prior to first participation in interscholastic athletics in middle school and prior to participation in high school. Clearance for continued participation is to be provided on this form prior to each subsequent year of interscholastic athletics. A yearly clearance from the examiner is needed for continued participation.

CHOICE OF EXAMINER: It is recommended that each child have a personal physician knowledgeable regarding each aspect of his/her health. Examination may be performed by a licensed physician (MD or DO), a licensed physician's assistant or a certificated pediatric or family nurse practitioner working under the direction of a physician whose name is to be stated.

THIS SECTION TO BE COMPLETED BY THE PARENT OR GUARDIAN BEFORE EXAMINATION BY THE PHYSICIAN. PLEASE PRINT.

Last name: First Middle Birthdate: Month/Day/Year Sex: M or F Name of school, camp, organization

Name of parent or guardian Address City Zip Home phone Work phone

Usual physician or source of health care Phone Dentist Phone

CIRCLE PURPOSE OF REPORT: **SCHOOL** - Preschool ChildFind Head Start ECEAP kindergarten elementary school middle school high school
To enter grade: ____ September, 20___ **INTERSCHOLASTIC ACTVITIES** - baseball basketball cross country football gymnastics soccer swimming tennis track volleyball wrestling
OTHER: daycare developmental center child study park board recreation boys club camp lifesaving other (specify) ______

IS THERE ANY ILLNESS, DISABILITY, LIFE THREATENING CONDITION or other situation which might affect performance? (please explain)

CHILD HAS HAD THE FOLLOWING: Circle the appropriate item(s) and explain on the right. Name other doctors important in child's care

SKIN: acne, eczema
VISION: glasses, contacts
HEARING: aids
NOSE: bleeding
MOUTH: dental decay, orthodontia
LUNGS: asthma, bronchitis
HEART: congenital, rheumatic
GASTROINTESTINAL: ulcer, colitis, hepatitis
GENITOURINARY: kidney or bladder infection
If female, menstruating: Yes ( ) No ( )

ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip
NEUROLOGICAL: convulsions, meningitis, cerebral palsy
METABOLIC: diabetes
BLOOD: anemia, sickle cell disease
ALLERGIES: ☐ food______ ☐ insect_____ ☐ pollen_____ ☐ peanut____ ☐ contact____ ☐ drugs ________
other (specify) ______
HOSPITALIZATION(S): (year and reason) ______
OPERATION(S): (year and reason) ______
DISABILITY: physical( ) mental( ) behavioral( ) social( ) learning( ) vision( ) hearing( ) speech( ) ADHD( )
Has child had: rubeola( ) rubella( ) mumps( ) chicken pox( ) whooping cough( )

If child is under 3 years, give birthweight __________ Describe unusual factors regarding birth or health immediately after birth: ______

IMMUNIZATIONS	None	Doses received 1	2	3	4	5 or more	Month/Day/Year	Immunizations
Diphtheria, Tetanus, Pertussis Any combination of DTaP								DTaP/TD (circle dose given)
Oral Polio Vaccine (OPV) Injectable Polio Vaccine (IPV)								OPV/IPV (Circle dose given)
MMR (Measles, Mumps, Rubella)								MMR
Hemophilus Influenza B Vaccine								Hemophilus
Hepatitis B								Hepatitis B
Varicella								Varicella

THIS SECTION IS THE RESPONSIBILITY OF THE PHYSICIAN. PARENT(S) SHOULD BE PRESENT FOR EXAMINATION.

Date of Examination Height Weight Blood Pressure Hearing: Right Left Tympanogram: Right Left Hematocrit Hemoglobin Sickle Cell Urinalysis

Vision: Right 20/ Left 20/ Vision Corrected: Right 20/ Left 20/ Glasses - Contacts (circle one) Color Vision Tuberculosis risk screen circle one: Low *High *Tuberculosis skin test: Date Type Result

CIRCLE ABNORMAL AREAS - DISCUSS AT RIGHT
Appearance Scalp Throat Neurological
Development Head Chest Dental
Nutrition Eyes Lungs Genitalia
Acne Ears Heart Extremities
Rashes Nose Abdomen Back (shows no evidence of Kyphosis or Scoliosis)

ANY CONDITION (CIRCLE):
Eczema Allergy
Asthma/exercise induced asthma
Obesity Lung
Heart Orthopedic
Diabetes: Other: ______

An additional narrative report is attached or will be forwaded - Yes ( ) No ( )

INTERVAL NOTE: Identify any occurrences since examination which could affect participation in school, athletics or other activities

REFERRAL(S) (circle) eye, ear, dental, orthopedic, other (describe) ______ Parents need help to obtain - Yes ( ) No ( )
Please name other doctors involved in care of child:

RECOMMENDED PHYSICAL ACTIVITY:
- ☐ Full day care, preschool, physical education, sports or camp activity
- ☐ Swimming
- ☐ Modified or restricted activity (describe)
- ☐ Interscholastic athletics. If wrestling, not to go below what weight? ________lbs.

MINIMUM WEIGHT - ***REQUIRED FOR WRESTLERS ONLY***
101 108 115 122 129 135 141 148
158 168 178 188 Unlimited

A physician's written release is required to resume participation following an illness and or injury serious enough to require medical care. Give details above.

Date signed Next recommended date of examination Physician's name (please print or stamp) Signature and title Phone

Prepared by the Pierce County Medical Society in cooperation with Tacoma and Pierce County preschools and schools, Tacoma-Pierce County Health Department, DSHS, child care, youth and camping organizations. Please call PCMS, 572-3666 or visit website www.pcmswa.org for master copy. Updated 9/2003.