

Pierce County HEALTH REPORT

Forwarded to School Nurse/RN for review

TIME OF EXAMINATION: For athletics, exams must be given during the 12-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 ACTIVITIES** - baseball basketball cross country football gymnastics soccer swimming tennis track volleyball wrestling
OTHER: daycare developmental center child study park board recreation boys dub 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

<p>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 () If child is under 3 years, give birthweight _____</p>	<p>ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip NEUROLOGICAL: convulsions, meningitis, cerebral palsy METABOLIC: diabetes BLOOD: anemia, sickle cell disease ALLERGIES: <input type="checkbox"/> food _____ <input type="checkbox"/> insect _____ <input type="checkbox"/> pollen _____ <input type="checkbox"/> peanut _____ <input type="checkbox"/> contact _____ <input type="checkbox"/> 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()</p>
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Describe unusual factors regarding birth or health immediately after birth: _____

IMMUNIZATIONS	None	Doses received					Month/Day/Year	Immunizations
		1	2	3	4	5 or more		
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	Left	Vision Corrected: Right	Left	Glasses - Contacts	Color Vision	Tuberculosis risk screen	*Tuberculosis skin test: Date	Type	Result		
20/	20/	20/	20/	(circle one)		circle one: Low *High					

<p>CIRCLE ABNORMAL AREAS - DISCUSS AT RIGHT</p> <table style="width: 100%;"> <tr> <td>Appearance</td> <td>Scalp</td> <td>Throat</td> <td>Neurological</td> </tr> <tr> <td>Development</td> <td>Head</td> <td>Chest</td> <td>Dental</td> </tr> <tr> <td>Nutrition</td> <td>Eyes</td> <td>Lungs</td> <td>Genitalia</td> </tr> <tr> <td>Acne</td> <td>Ears</td> <td>Heart</td> <td>Extremities</td> </tr> <tr> <td>Rashes</td> <td>Nose</td> <td>Abdomen</td> <td>Back (shows no evidence of Kyphosis or Scoliosis)</td> </tr> </table>	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)	<p>ANY CONDITION (CIRCLE):</p> <p>Eczema Allergy Asthma/exercise induced asthma Obesity Lung Heart Orthopedic Diabetes: Other: _____</p>
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)																		

An additional narrative report is attached or will be forwarded - 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: _____

<p>RECOMMENDED PHYSICAL ACTIVITY:</p> <p><input type="checkbox"/> Full day care, preschool, physical education, sports or camp activity <input type="checkbox"/> Swimming <input type="checkbox"/> Modified or restricted activity (describe) _____ <input type="checkbox"/> Interscholastic athletics. If wrestling, not to go below what weight? _____ lbs.</p>	<p>MINIMUM WEIGHT - REQUIRED FOR WRESTLERS ONLY</p> <table style="width: 100%;"> <tr> <td>101</td> <td>108</td> <td>115</td> <td>122</td> <td>129</td> <td>135</td> <td>141</td> <td>148</td> </tr> <tr> <td>158</td> <td>168</td> <td>178</td> <td>188</td> <td colspan="4">Unlimited</td> </tr> </table>	101	108	115	122	129	135	141	148	158	168	178	188	Unlimited			
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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
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