# ALTOONA AREA SCHOOL DISTRICT
# SCHOOL HEALTH SERVICES
# PHYSICAL EXAMINATION

Dear Parent/Guardian:

The Pennsylvania School Law requires all school age children to have periodic physical examinations as follows: kindergarten or grade one, grade six and grade eleven. Transfer students, as well as students with incomplete health records, shall be required to have a physical examination as the need arises.

I am recommending the examination is completed by your family physician since he/she can best evaluate your child's health. The private physician's report form needs to be completed by your family physician and returned to the school nurse by: December 2016

Completed private examination forms must be returned prior to the date the school examinations are scheduled or your child will be scheduled for a medical examination at school. If you wish to be present for the examination, please submit your request in writing before the scheduled physical exam.

If you have any questions regarding this health program requirement, please contact me at 946-8465 ext. 5211 or email me at pburkey@altoonasd.com

Sincerely,

School Nurse

Padget C. Burkey RN.

Check with your physician re: Immunizations

Child needs:

2 MMR
2 Varicella
3 Hepatitis B
3 Polio
5 DPT (last DPT must be after 4yrs of age)

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

# Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

**PARENT / GUARDIAN / STUDENT:**
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: ☐ Male ☐ Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.**

| GENERAL HEALTH: Has the student... | YES | NO |
|---|---|---|
| 1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____ | | |
| 2. Ever stayed more than one night in the hospital? | | |
| 3. Ever had surgery? | | |
| 4. Ever had a seizure? | | |
| 5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ? | | |
| 6. Ever become ill while exercising in the heat? | | |
| 7. Had frequent muscle cramps when exercising? | | |
| **HEAD/NECK/SPINE: Has the student...** | **YES** | **NO** |
| 8. Had headaches with exercise? | | |
| 9. Ever had a head injury or concussion? | | |
| 10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling? | | |
| 12. Ever been unable to move arms or legs after being hit or falling? | | |
| 13. Noticed or been told he/she has a curved spine or scoliosis? | | |
| 14. Had any problem with his/her eyes (vision) or had a history of an eye injury? | | |
| 15. Been prescribed glasses or contact lenses? | | |
| **HEART/LUNGS: Has the student...** | **YES** | **NO** |
| 16. Ever used an inhaler or taken asthma medicine? | | |
| 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____ | | |
| 18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)? | | |
| 19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise? | | |
| 20. Had discomfort, pain, tightness or chest pressure during exercise? | | |
| 21. Felt his/her heart race or skip beats during exercise? | | |
| **BONE/JOINT: Has the student...** | **YES** | **NO** |
| 22. Had a broken or fractured bone, stress fracture, or dislocated joint? | | |
| 23. Had an injury to a muscle, ligament, or tendon? | | |
| 24. Had an injury that required a brace, cast, crutches, or orthotics? | | |
| 25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury? | | |
| 26. Had joints that become painful, swollen, feel warm, or look red? | | |
| **SKIN: Has the student...** | **YES** | **NO** |
| 27. Had any rashes, pressure sores, or other skin problems? | | |
| 28. Ever had herpes or a MRSA skin infection? | | |

| GENITOURINARY: Has the student... | YES | NO |
|---|---|---|
| 29. Had groin pain or a painful bulge or hernia in the groin area? | | |
| 30. Had a history of urinary tract infections or bedwetting? | | |
| 31. FEMALES ONLY: Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____ | | |
| **DENTAL:** | **YES** | **NO** |
| 32. Has the student had any pain or problems with his/her gums or teeth? | | |
| 33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years | | |
| **SOCIAL/LEARNING: Has the student...** | **YES** | **NO** |
| 34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.? | | |
| 35. Been bullied or experienced bullying behavior? | | |
| 36. Experienced major grief, trauma, or other significant life event? | | |
| 37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends? | | |
| 38. Been worried, sad, upset, or angry much of the time? | | |
| 39. Shown a general loss of energy, motivation, interest or enthusiasm? | | |
| 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight? | | |
| 41. Used (or currently uses) tobacco, alcohol, or drugs? | | |
| **FAMILY HEALTH:** | **YES** | **NO** |
| 42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____ | | |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____ | | |
| 44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning? | | |
| 45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)? | | |
| **QUESTIONS OR CONCERNS** | **YES** | **NO** |
| 46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.) | | |

**I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.**

Signature of parent / guardian / emancipated student _____ Date _____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

| Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐ | CHECK ONE: NORMAL | *ABNORMAL | DEFER | *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS |
|---|---|---|---|---|
| Height: ( ) inches | | | | |
| Weight: ( ) pounds | | | | |
| BMI: ( ) | | | | |
| BMI-for-Age Percentile: ( ) % | | | | |
| Pulse: ( ) | | | | |
| Blood Pressure: ( / ) | | | | |
| Hair/Scalp | | | | |
| Skin | | | | |
| Eyes/Vision Corrected ☐ | | | | |
| Ears/Hearing | | | | |
| Nose and Throat | | | | |
| Teeth and Gingiva | | | | |
| Lymph Glands | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Genitourinary | | | | |
| Neuromuscular System | | | | |
| Extremities | | | | |
| Spine (Scoliosis) | | | | |
| Other | | | | |

| TUBERCULIN TEST | DATE APPLIED | DATE READ | RESULT/FOLLOW-UP |
|---|---|---|---|
| | | | |
| | | | |

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address _____ Phone_____

Signature of examiner _____ MD ☐ DO ☐ PAC ☐ CRNP ☐

# ALTOONA AREA SCHOOL DISTRICT
# STUDENT HEALTH SERVICES
# DENTAL EXAMINATION

Dear Parent or Guardian:

Pennsylvania School Law requires a dental examination on all children entering school, kindergarten or 1st grade, 3rd grade and 7th grade. The examination may be done in school or by your family dentist.

We recommend your family dentist do this examination since he/she can best evaluate your child's dental health and assist you in obtaining the necessary treatments and corrections.

Please return the dental forms by December, 2016.

**According to STATE LAW, if a private dentist's form is not returned, the examination will be scheduled and done by the school dentist. If you wish to be present while the examination occurs, please submit your request in writing prior to the scheduled date.**

School Dental Examination Scheduled: Usually Jan/Feb 2017

Respectfully,

School Nurse

Gadget Burkey RN
946-8465
ext. 5211

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

# PRIVATE DENTIST REPORT
# OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

| NAME OF CHILD | AGE | SEX | GRADE | SECTION/ROOM |
|---|---|---|---|---|
| Last First Middle | | ☐ M ☐ F | | |

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

## REPORT OF EXAMINATION

TOOTH CHART

| | | RIGHT | | | | | | | | LEFT | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UPPER | | 1 | 2 | 3 | 4 A | 5 B | 6 C | 7 D | 8 E | 9 F | 10 G | 11 H | 12 I | 13 J | 14 | 15 | 16 | Upper |
| LOWER | | 32 | 31 | 30 | 29 T | 28 S | 27 R | 26 Q | 25 P | 24 O | 23 N | 22 M | 21 L | 20 K | 19 | 18 | 17 | Lower |
| | UPPER | | | | | | | | | | | | | | | | | Upper |
| | LOWER | | | | | | | | | | | | | | | | | Lower |

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address

ALTOONA AREA SCHOOL DISTRICT
Student Health Services
STUDENT HEALTH HISTORY

Child's Full Name: _____ Birthday: _____
Last First Middle Month Day Year

Address: _____ Telephone # _____
_____ Place of Birth: _____
Father's Name: _____ Occupation: _____
Mother's Name: _____ Occupation: _____
Guardian's Name: _____ Occupation: _____

Give names and birth date of other children in the family:

| Name | Date of Birth | Name | Date of Birth |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Child's Physician: _____ Child's Dentist: _____

Does your child have any special health needs or problems that will require attention or assistance in school?

_____

Does your child need a special diet or have any food problems? (Give details):

_____

Is there any reason why your child should not participate in physical education classes? (Give details)

_____

Is your child taking any medications other than vitamins, regularly? Give name of medication/s and reason?

_____

Is your child presently being treated for any health problems? (Give details):

_____

MEDICAL HISTORY: (Check any of the following your child has had and indicate age of occurrence.)

| | AGE | | AGE |
|---|---|---|---|
| ____ Chickenpox | _____ | ____ Rheumatic Fever | _____ |
| ____ Measles (Regular) | _____ | ____ Lead Poisoning (Highest Level) | _____ |
| ____ Rubella (German Measles) | _____ | ____ Pneumonia | _____ |
| ____ Mumps | _____ | ____ Seizures (Epilepsy) | _____ |
| ____ Whopping Cough | _____ | ____ Head Injury | _____ |
| ____ Scarlet Fever | _____ | ____ Eye Surgery | _____ |

Does your child have complete bowel and bladder control? _____

Has your child ever been hospitalized or had an operation? (If Yes, When, where, for what?)

_____

Has your child had any serious illness, accident, or broken bones? (If Yes, when, where, what?)

_____

_____ Date: _____

Name of Parent or Guardian (Please Print)

_____

Signature of Parent or Guardian