

## **2009-2010 Health Forms Packet**

### **Forms - in Order**

**Physical Evaluation Form** - Kindergarten, transfers, incoming 6<sup>th</sup>

**Dental Form** - Kindergarten, transfers, incoming 3rd & 7<sup>th</sup>

**Hike/Interscholastic Form** - Every student in every grade

**2009-2010 Health History Form** - Every student in every grade

### **Form Due Dates:**

Kindergarten & transfer Students - August 30<sup>th</sup>

Returning GWCS Students Deadline - 1st Day of School

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

**PRIVATE PHYSICIAN'S REPORT OF  
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE \_\_\_\_\_ 20 \_\_\_\_\_

NAME OF SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ HOMEROOM \_\_\_\_\_

NAME OF CHILD _____ Last First Middle	DATE OF BIRTH _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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ADDRESS

\_\_\_\_\_

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

**MEDICAL HISTORY  
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /		2 / /		3 / /
HIB	1 / /		2 / /		3 / /
Varicella	1 / /		2 / /		Varicella Disease or Lab Evidence Date: _____
Other _____					

- MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

**If Applicable:**

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on.

Date

Result of Diagnostic Studies: \_\_\_\_\_

Date

Preventive Anti-Tuberculosis - Chemotherapy ordered.  No  Yes \_\_\_\_\_  
Date

(Continued on Back)

**Significant Medical Conditions (✓)**

	Yes	No	If Yes, Explain
Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify \_\_\_\_\_

**Report of Physical Examination (✓)**

	Normal	Abnormal	Not Examined	Comments
● Height (inches)				
● Weight (pounds)      BMI				
● Pulse (      )				
● Blood Pressure      /				
● Hair/Scalp				
● Skin				
● Eyes/Vision				
● Ears/Hearing				
● Nose and Throat				
● Teeth and Gingiva				
● Lymph Glands				
● Heart — Murmur, etc.				
● Lung — Adventitious Findings				
● Abdomen				
● Genitourinary				
● Neuromuscular System				
● Extremities				
● Spine (Presence of Scoliosis)				

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature of Examiner

\_\_\_\_\_  
**Print** Name of Examiner

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS \_\_\_\_\_

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



**Green Woods Charter School  
Hike and Interscholastic Athletic Participation  
2009-2010**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**TO THE MEDICAL CARE PROVIDER**

Class hiking is required of all our students and is an integral component of the academic curriculum at Green Woods Charter School. The students hike daily into the **steep trails on 340 acres of isolated woods which contain many asthma and allergy triggers that students are typically not exposed to in an indoor classroom environment.** At times, the students are a distance from the school building.

By signing this form, you are stating that the student is physically able to participate in daily **rigorous hiking, asthma is under control, student does not have a cardiac condition or any other physical condition** that may put their health and safety at **risk** while participating in our unique academic curriculum.

I have examined the student on this form. Yes \_\_\_\_\_ No \_\_\_\_\_

I find this student physically qualified to practice and participate in ALL competitive games/sports/hiking. Yes \_\_\_\_\_ No \_\_\_\_\_

List any special instructions or limitations for any physical participation

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Physician**

**Address & Telephone**

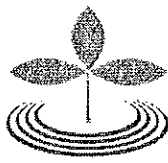
**(Date)**

*I hereby give consent for my child to practice for and participate in ALL games/sports and hiking. I am fully aware of my child's health condition and limitations, if any. I am allowing my child to receive any emergency treatment deemed necessary by medical personnel.*

**Signature of Parent**

**Date**

\_\_\_\_\_  
\_\_\_\_\_



# Green Woods Charter School

THE WORLD IN OUR HANDS

## HEALTH HISTORY FORM 2009-2010 SCHOOL YEAR

Student Name	_____	Grade	_____	Date	_____
Date of Birth	_____	Age	_____	Date of Last Physical	_____
Home Address	_____				
Name of Parents/Guardians	_____				
Home #	_____	Work#	_____	Cell#	_____
Additional Emergency Contact:	_____				
Relationship	_____	Phone#	_____		
E-mail address	_____				
Student's Physician	_____	Phone#	_____		
Health Insurance	_____				
Policy #	_____				
Student's Dentist	_____	Phone#	_____		
Date of last dental exam	_____				
Student's Optometrist	_____	Phone#	_____		
Date of last eye exam	_____				

<b>Disease/Illness History</b>		
An injury/fracture or illness since last physical? Explain _____	Yes	No
Surgery, hospitalizations or any other Emergency Room visits? Explain _____	Yes	No
A chronic or ongoing illness (such as diabetes or asthma)? Name of illness _____	Yes	No
An inhaler or other prescription medicine to control chronic illness? Name of medication _____	Yes	No

<b>Asthma</b>		
Asthma symptoms brought on by weather changes: humidity cold	Yes	No
Exercised induced asthma?	Yes	No
Upper Respiratory Infection induced asthma?	Yes	No
Seasonal environmental allergy induced asthma? Pollen?	Yes	No
Your child's best Peak Flow reading ** _____ **		
List Asthma Medications:		
Daily maintenance medications: _____		
Rescue Medications: _____		

<b>Allergies</b>		
Medication allergy?	Yes	No
Name of medication _____		
Describe reaction _____		
Food allergy?	Yes	No
Food/s allergic to: _____		
Describe reaction _____		
Latex allergy?	Yes	No
Describe reaction _____		
Bee sting/insect sting allergy?	Yes	No
Describe reaction _____		
Any other allergies?	Yes	No
Explain _____		

Seizures	Yes	No
Type of seizures _____		
Name of seizure medication _____		
Frequent nose bleeds?	Yes	No
Menstruation? Onset? _____	Yes	No
Cardiac/Heart Diagnosis? circle murmur? VSD? PDA?	Yes	No
Explain _____		
Anemia, blood disorders, sickle cell disease/trait?	Yes	No
Explain _____		
Lyme Disease? Date _____	Yes	No
Obesity? BMI above 85%	Yes	No
Healthy Body Plan: _____		
Please list any condition your child may have which might limit his/her activities at school. _____		
Vision Loss/Correction eyeglasses contacts	Yes	No
Hearing Loss hearing aides or implants	Yes	No

ADD/ADHD?	Yes	No
Name of medication _____		
Special Education Services? circle IEP? 504?	Yes	No
Psychological/Psychiatric (anxiety, depression, other)	Yes	No
Explain _____		
Name of medication for psychiatric disorder _____		
Has there been any changes in your family during the past year, such as:		
Separation, divorce or remarriage?	Yes	No
Death or serious illness	Yes	No
Any other situation that might affect your child?	Yes	No
PLEASE EXPLAIN ON NEXT PAGE...		

Explain (include relevant dates)

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List **ALL** medications here:

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide dates and documentation from physician on immunizations received since our last school year.

Varicella (chickenpox) \_\_\_\_\_ Td (booster) \_\_\_\_\_ HPV (cervical cancer) \_\_\_\_\_

Menactra (meningococcal & meningitis) \_\_\_\_\_ Influenza (annual flu) \_\_\_\_\_

**Permission To Receive Over The Counter Medication**

The School Nurse has standing orders from GWCS physician to administer specific over the counter medication to your child. Your child must have had the medication in the past and will not be receiving it for the first time.

The school nurse has my permission to administer the following medication (check ALL that you give your permission for). Per our Health Room orders from our school physician no medication of any kind will be given to a student the first or last period of the school day.

Tylenol (acetaminophen)     Advil, Motrin (ibuprofen)  
 Tums (antacids)     Caladryl (topical itch relief)  
 Benadryl (allergic reactions only)     Epi-Pens (acute allergic reaction!)  
 DO NOT give any medications without a phone call to me first

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent For Medical Information**

There may be occasions on which we need to contact your physician or dentist for health information.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_