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 _____

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 ☐**

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)

DL-180 (12-10)

pennsylvania
DEPARTMENT OF TRANSPORTATION
BUREAU OF DRIVER LICENSING

NON-COMMERCIAL LEARNER'S PERMIT APPLICATION

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

YOU MUST APPLY IN PERSON

THIS FORM IS VALID FOR 1 YEAR FROM THE DATE OF PHYSICAL EXAMINATION
The physical date may not be more than 6 months prior to your 16th birthday.

DRIVER'S LICENSE NUMBER/I.D. NUMBER: _____

LAST NAME (S)	JR./ETC

FIRST NAME	MIDDLE NAME

DATE OF BIRTH			HEIGHT		SOCIAL SECURITY NUMBER	SEX	TELEPHONE NUMBER (8:00A.M. - 4:30P.M.)
MONTH	DAY	YEAR	FEET	INCHES			

EYE COLOR *(Please check one)*: ☐ BLUE ☐ BROWN ☐ GREEN ☐ HAZEL ☐ PINK ☐ BLACK ☐ GRAY ☐ DICHROMATIC ☐ OTHER _____

STREET ADDRESS - *A Post Office Box number may be used in addition to the actual residence address, but cannot be used as the only address.*	CITY	STATE	ZIP CODE

CHECK DESIRED PERMIT(S)	PERMIT(S) DESIRED	FEE	ENTER FEE FOR EACH ITEM CHECKED
☐	CLASS A (Combination Vehicle over 26,000), ☐ CLASS B (Truck or Bus over 26,000) OR ☐ CLASS C (Automobile)	$5.00	
☐	CLASS M (Motorcycle) MSEA Fee is included	$15.00	

MUST CHECK ONE	LICENSE REQUIRED	FEE	ENTER FEE FOR LICENSE CHECKED
☐	4-Year Photo	$29.50	
☐	2-Year Photo (Age 65 & Over)	$19.00	
☐	Organ Donation Awareness Trust Fund (I wish to contribute $1.00)	$1.00	

PAID BY: ☐ Check ☐ Money Order Payable to PennDOT (Cash CANNOT be accepted) TOTAL $

ALL QUESTIONS MUST BE ANSWERED *(Check [✓] Applicable Block)* YES NO

1. Have you ever held or possessed a PA Driver's License/Learner's Permit/Photo Identification Card? ☐ ☐
2. Is your right to apply for a license or your privilege to operate a vehicle in this or any other state currently suspended, revoked, or subject to installation of an ignition interlock device? ☐ ☐
   If yes, give state _____ date _____, and reason _____
3. Have you been arrested or cited in this state or any other state for any violation, which carries a possible penalty of suspension or revocation of your driver's license or driving privilege? ☐ ☐
   If yes, give state _____ date _____, and reason _____
4. Do you hold a valid license or ID card from any other state? ☐ ☐

AUTHORIZATION AND CERTIFICATION

I certify under penalty of law that this information contained herein is true and correct. I hereby authorize the Social Security Administration to release to the Department of Transportation information concerning my Social Security Identification Number for the purpose of identification. I hereby acknowledge this day that I have received notice of the provisions of Section 3709 of the Vehicle Code. (See back for provisions)

WARNING: Misstatement of fact is a misdemeanor of the third degree punishable by a fine of up to $2,500 and/or imprisonment up to 1 year (18 Pa. C.S. Section 4904[b]).

☐ I am under the age of 18 years and I hereby request Organ Donor designation on my PA Driver's License. Parent must check consent block on the ParenGuardian Consent Form (DL-180TD). *(Applicants 18 years of age or older will have the opportunity to request Organ Donor designation at the Photo Center at the time they have their photo taken.)*

I hereby certify that I am a resident of the Commonwealth of Pennsylvania.

SIGN HERE _____ _____

(APPLICANT'S SIGNATURE IN INK) (DATE)

FOR OFFICIAL USE ONLY

VISION SCREENING CHECK (✓) YES NO

20/40 vision or less in better eye with correction .. ☐ ☐

Report of Eye Examination (attached) ..... ☐ ☐

☐ Qualified with Restrictions

☐ Corrective Lenses

☐ Other: _____

☐ Qualified Without Restrictions

COMPLETE ALL ITEMS		
Uncorrected		Corrected
20/	Right Eye	20/
20/	Left Eye	20/
20/	Both Eyes	20/
R L	Fields	R L

Classes which should be endorsed on the Driver's PA License.

☐ A ☐ B ☐ C ☐ M

EXAMINER'S DRIVER CERTIFICATION

This is to certify that the above applicant has applied for and passed the examination for the above class(es) for a Pennsylvania Driver's License.

_____ _____

(SIGNATURE OF EXAMINER) (DLE NO.)

DATE OF ISSUE:

MONTH	DAY	YEAR

EXAM CENTER:

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP____/____ (____/____ , ____/____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Date of CIPPE ___/___/___

Revised: July 26, 2012

Version: 10/06

Application: Section A – Athlete Health Information

Athlete Information:

PLEASE PRINT CLEARLY Area: _____

Athlete Name: _____ Gender: ☐ M ☐ F

Address: _____ Date of Birth (month/day/year) _____/_____/_____

City/State/Zip: _____ Home Phone: _____

E-mail Address: _____ Cell / Work Phone: _____

Parent/Guardian Information:

Parent/Guardian Name: _____ Home Phone: _____

Address (if different than athlete): Work Phone: _____

_____ Cell Phone: _____

_____ E-mail: _____

Emergency Contact Information: (other than parent/guardian): _____

Home Phone: _____ Cell / Work Phone: _____

Athlete Background Information – Answers are not automatic disqualifiers for participation in Special Olympics Virginia.

1) **Was the athlete ever charged or convicted of a crime?**
☐ Yes ☐ No

Explain YES answer and indicate date, location and nature of offense:

2) **Does the athlete have any behavior issues?**
☐ Yes ☐ No

Explain YES answer:

1.	Down Syndrome	☐ Yes ☐ No	13.	Impaired motor ability	☐ Yes ☐ No
	Have cervical spine (neck bone) x-rays ever been done?	☐ Yes ☐ No	14.	Uses a wheelchair	☐ Yes ☐ No
			15.	Allergy to the following (list specific)	☐ Yes ☐ No
	Atlanto-Axial Instability	☐ Yes ☐ No		Medicine _____	☐ Yes ☐ No
2.	Chest Pain or Fainting Spells	☐ Yes ☐ No		Foods _____	☐ Yes ☐ No
3.	Seizures/ Epilepsy	☐ Yes ☐ No		Insect Sting/Bite _____	☐ Yes ☐ No
4.	Diabetes	☐ Yes ☐ No	16.	Special diet _____	☐ Yes ☐ No
5.	Heart Disease/ Heart Defect/ High Blood Pressure	☐ Yes ☐ No	17.	Exercise induced wheezing	☐ Yes ☐ No
			18.	Tendency to bleed easily	☐ Yes ☐ No
6.	Parent/ Sibling (under 40) died of heart disease	☐ Yes ☐ No	19.	Emotional/ psychiatric/ behavioral problems	☐ Yes ☐ No
			20.	Serious bone or joint disorder	☐ Yes ☐ No
7.	Absence of vision/ blind in one eye	☐ Yes ☐ No ☐ NP	21.	Sickle cell trait or disease	☐ Yes ☐ No
8.	Absence of one kidney or testicle	☐ Yes ☐ No ☐ NP	22.	Hearing aid/ hearing loss	☐ Yes ☐ No
9.	Concussion or serious head injury	☐ Yes ☐ No ☐ NP	23.	Contact lenses/ eyeglasses	☐ Yes ☐ No
10.	Major surgery or serious illness	☐ Yes ☐ No ☐ NP	24.	Dentures/ false teeth	☐ Yes ☐ No
11.	Heat stroke/ exhaustion	☐ Yes ☐ No ☐ NP	25.	Immunizations (shots) are up-to-date	☐ Yes ☐ No
12.	Other problem that would interfere with sports participation	☐ Yes ☐ No ☐ NP	26.	Date of last tetanus shot _____/_____/_____	

List: _____

_____

A physical examination performed by a licensed examiner is required every 3 years for athletes with YES in items 1-6. An exam is required the first time NP (New Problem) is checked in items 7-12.

Comments: _____

_____

Medication Update * Attach additional sheet if needed.	Medication Name	Amount (eg. 250 mg)	Date Prescribed	Amount Taken (Dosage and instructions, ex. 250 mg 2 X per day with food)

Phone: _____

Signature of Person Completing Section A: _____ Relationship to athlete: _____ Date: _____

Columbiana County Head Start
7880 Lincole Place
Head Start Center: Lisbon, OH 44432 (330) 424-7221

Child's Name: _____ Sex: _____ Birthdate: _____

Address _____ Phone: _____

1. Relevant Information

2. Screening Tests: Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. **Enter dates if done previously.** When recording results, enter at a minimum "N" Normal "S" Suspect, or "A" for Atypical/Abnormal.
(* Required screens: Height, Weight, Hearing, Vision, Lead, and either Hematocrit or Hemoglobin)

Test	Date	Results
a. **Present age**		____Yrs. ____Mos.
b. **Height** (no shoes to nearest 1/8 in.) *		
c. **Weight** (light clothing to nearest ¼ lb.)*		
d. **Blood Pressure**		
e. **Hematocrit** or **Hemoglobin** *		
f. **Hearing** (Type of Test) *		
Results R / L *	_____	_____
Re-screening	_____	_____
Comments		
g. **Lead** *		

Test	Date	Results
h. **Vision** (Type of Test)*		
Acuity R / L	_____	_____
Re-screening	_____	_____
Strabismus	_____	_____
Comments	_____	_____
i. **Other Tests** (If Needed)		
(1) TB	_____	_____
(2) Sickle Cell	_____	_____
(3) Ova & Parasites	_____	_____
(4) Urinalysis	_____	_____
5) Other	_____	_____

3. Physical Examination Assessment

	Normal For Age	Abnormal	Not Eval.
a. General Appearance			
b. Posture			
c. Speech			
d. Head			
e. Skin			
f. Eyes 1) External Aspects			
2) Optic Fundiscopic			
3) Cover Test			
g. Ears 1) External & Canals			
2) Tympanic Membranes			
h. Nose, Mouth, Pharynx			
i. Teeth			
j. Heart			
k. Lungs			
l. Abdomen (include hernia)			
m. Genitalia			
n. Bones, Joints, Muscles			
o. Neurological/Social			
(1) Gross Motor	_____	_____	_____
(2) Fine Motor	_____	_____	_____
(3) Communication Skills	_____	_____	_____
(4) Cognitive	_____	_____	_____
(5) Self-Help Skills	_____	_____	_____
(6) Social Skills	_____	_____	_____
p. Glands (lymphatic/Thyroid)			
r. Other			

	First	Second	Third	Fourth	Fifth
Polio					
DTaP					
MMR					
Hib					
Hepatitis B					
Varicella					
Hepatitis A					
PCV					
Influenza					
Other 1					
Other 2					
Other 3					

Additional Comments (Use additional sheet if necessary)

s. **General Statement on Child:** This child has been found to be free of Communicable Disease and is in suitable condition to participate in a child care setting.

Name of Physician (Please Print)	Telephone Number ( )
Street Address	
City, State and Zip Code	
Physician's Signature:	Date of Physician's Signature

White Copy: Office **Yellow** Copy: Center **Pink** Copy: Other Rev. 07/08