

PART 2 HEALTH EVALUATION
- To be completed by physician/nurse practitioner -

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school (e.g., seizures, asthma insect sting allergy, bleeding problem, diabetes, heart problem)? If "Yes", please describe.

No Yes _____

2. Is this child on long-term technology assistance? No Yes _____

3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a check (✓) in the appropriate box.

CONCERN

| Health Area | Yes | No | Not Evaluated | Health Area | Yes | No | Not Evaluated |
|---------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adjustment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nutrition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech/Language | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical/Illness/Impairment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Development | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunodeficiency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Attention Deficit/Hyperactivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lead Poisoning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain all yes answers. Include recommendations for referral and treatment.

4. Immunizations given on this visit: DPT/Td # _____; Polio # _____; MMR # _____; Other _____

5. Tuberculin Test: Results Positive Negative _____
 Type _____ Date (most recent) _____ Height _____ Weight _____ BP _____ Pulse Rate _____ Date Taken _____

6. Is the student on long-term medication? If yes, please describe.
 No Yes _____
 (MCPS Form 525-13: Authorization to Administer Prescribed Medication must be completed for in-school administration)

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
 No Yes _____

8. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed below that are **NOT CROSSED OUT**?

No Yes Not Applicable

| | | | |
|---------------|--------------|-----------------|----------------------------|
| Baseball | Football | Pompons | Track/Field |
| Basketball | Golf | Soccer | Volleyball |
| Cheerleading | Gymnastics | Softball | Wrestling (minimum weight) |
| Cross Country | Indoor Track | Swimming/Diving | Other (specify) _____ |
| Field Hockey | Lacrosse | Tennis | _____ |

If you would like to discuss this student's health with school or school health personnel, check title below

Nurse assigned to school Teacher Counselor Principal

Student Name (Type/print) _____ has had a complete history and physical examination in our office and has no evident health problem except as noted above.

 Physician/Nurse Practitioner (Print) Phone Number Original Signature, Physician/Nurse Practitioner Date

IMPORTANT: Maryland Immunization Certification is required by law. Please complete Form DHMH 896.