❑ Forwarded to School Nurse/RN for review

PIERCE COUNTY MEDICAL SOCIETY

Pierce County Health Report

TIME OF EXAMINATION: *For athletics, exams must be given during the 24-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: *Is 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 FO), a licensed physician's assistant or a certified 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 _____ Sex ❑ M ❑ F

Birthdate *(Month/Day/Year)* _____ Name of School, Camp, Organization _____

Parent/Guardian Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ Zip _____

Physician _____ Phone _____ Dentist _____ Phone _____

Circle Choices **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 Development Center Child Study Park Board Recreation Boys Club Camp Lifesaving Other *(specify)* _____

IS THERE ANY ILLNESS, DISABILITY, LIFE THREATENING CONDITION or other situation which might affect performance? *Please explain.*

_____

CHILD HAS THE FOLLOWING *Circle the appropriate item(s) and explain on the right. Name other doctors important in child's care* _____

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

ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip

NEUROLOGICAL: convulsions, meningitis, cerebral palsy

METABOLIC: diabetes

BLOOD: anemia, sickle cell disease

ALLERGIES: ❑ Food _____ ❑ insect _____ ❑ pollen _____ ❑ peanut _____

❑ contact _____ ❑ drugs _____ ❑ other *(specify)* _____

HOSPITALIZATION(S) *(year and reason)* _____

OPERATION(S) *(year and reason)* _____

DISABILITY: physical mental behavioral social learning vision hearing speech ADHA

HAS CHILD HAD: rubeola rebella mumps chicken pox whooping cough

If child is under 3 years, give birthweight _____ *Describe unusual factors regarding birth or health immediately after birth* _____

Immunizations	None	Doses Received					Month/Day/Year
		1	2	3	4	5 *or more*	
Diphtheria, Tetanus, Pertussis, Any Combination of DTaP ❑ DTaP ❑ TD *(check dose given)*							
Oral Polio Vaccine (OPV) Injectable Polio Vaccine (IPV) ❑ OPV ❑ IPV *(check dose given)*							
MMR (Measles, Mumps, Rubella)							
Hemophilus Influenza B Vaccine							
Hepatitis B							
Varicella							

continued on back >

PIERCE COUNTY MEDICAL SOCIETY

PIERCE COUNTY HEALTH REPORT
(Continued)

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 20/___ Left 20/___ Vision Corrected: Right 20/___ Left 20/___ ❑ Glasses ❑ Contacts *(check one)* Color Vision _____

Tuberculosis Risk Screen: ❑ Low ❑ *High *(check one)* *Tuberculosis Skin Test: Date _____ Type _____ Result _____

CIRCLE ABNORMAL AREAS (*discuss at right)*

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)*

CIRCLE ANY CONDITION

Eczema	Allergy	Obesity	Asthma/Exercise Induced Asthma
Lung	Heart	Orthopedic	Diabetes

Other:

An additional narrative report is attached or will be forwarded? ❑ Yes ❑ No *(check one)*

INTERVAL NOTE: Identify any occurrences since examination which could affect participation in school, athletics or other activities

REFERRAL(S) ❑ Eye ❑ Ear ❑ Dental ❑ Orthopedic ❑ Other *(describe)* _____

Parents need to help to obtain ❑ Yes ❑ No Please name other doctors involved in care of child: _____

RECOMMENDED PHYSICAL ACTIVITY

❑ Full day care, preschool, physical education, sports or camp

❑ Swimming

❑ Modified or restricted activity *(describe)*

❑ Interscholastic athletics. If wrestling, not to go below what weight? _____lbs

Minimum Weight - REQUIRED FOR WRESTLERS ONLY *(check one)* 101 108 115 122 129 135 141 148 158 168 178 188 Unlimited

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 _____

Prepared by the Pierce County Medical Society in cooperation with Tacoma and Pierce County preschools and schools, Tacoma-Pierce County Health Department, DSHS, child care, youth and camping organizations. Please call PCMS, 253-572-3667 or visit website www.pcmswa.org for master copy.