#6: Medical Information for Physician

To be completed by Health Care Provider. ***If "yes" to any item, please explain (attach addendum, if needed).***

Birth History/Developmental (age 0-6 yrs.)

☐ Uncomplicated ☐ Premature _____ Weeks' Gestation ☐ Complicated by _____

☐ Within normal limits. If delay suspected, specify below.

☐ Cognitive (e.g., play skills _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

Does the child/adolescent have a past or present medical history of the following?

☐ Attention Deficit Hyperactivity Disorder

☐ Chronic or recurrent otitis media

☐ Congenital or acquired heart disorder

☐ Developmental/learning problem

☐ Orthopedic injury/disability

☐ Asthma ***(check severity and attach MAF/Asthma Action Plan):***

☐ Speech, hearing, or visual impairment

☐ Speech, hearing, or visual impairment

☐ Diabetes *(attach MAF)*

☐ Seizure disorder

☐ **Other** *(specify)* _____

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s):

☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

Explain all checked items above on an addendum

General Appearance/Physical Examination

Height _____ ins (___ ___ %ile) BMI _____ (___ ___ %ile)

Weight _____ lbs (___ ___ %ile) Head Circumference *(age ≤2 yrs)* _____ ins (___ ___ %ile)

Blood Pressure (age > 3 yrs. ___ / ___

Nl	*Ab*		*Nl*	*Ab*		*Nl*	*Ab*	
☐	☐	HEENT	☐	☐	Cardiovascular	☐	☐	Lymph nodes
☐	☐	Dental	☐	☐	Neurological	☐	☐	Lungs
☐	☐	Neck	☐	☐	Back/spine	☐	☐	Psychosocial Development
☐	☐	Lymph nodes	☐	☐	Extremities	☐	☐	Language
☐	☐	Lungs	☐	☐	Skin	☐	☐	Behavioral

Describe Abnormalities on addendum

ALLERGIES

☐ None ☐ Epi Pen Prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

SCREENING TESTS

	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	_____	☐ _____ µg/dL
	_____	☐ _____ µg/dL
Lead Risk Assessment At risk *(do BLL)(annually, age 6 mo-6 yrs)*	_____	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	_____	☐ Normal ☐ Abnormal
Vision *for new members Left ___ / ___and children age 4–7 yrs*	_____	**Acuity** Right ___ / ___ Left ___ / ___ ☐ With glasses **Strabismus** ☐ No ☐ Yes

IMMUNIZATIONS – DATES

CIR Number of Child ☐☐☐☐☐☐☐☐☐

Hep B	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Rotavirus	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
DTP/DTaP/DT	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
DTP/DTaP/DT	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Hib	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
PCV	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Polio	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Influenza	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
MMR	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Varicella	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Td	-	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Tdap	__ __/__ __/__ __	**Hep A**	__ __/__ __/__ __	__ __/__ __/__ __
Meningococcal	-	__ __/__ __/__ __	__ __/__ __/__ __	-
HPV	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Other, *specify:*	_____	__ __/__ __/__ __	_____	__ __/__ __/__ __

ASSESSMENT

☐ Well Child (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ ___ ___ ___ ___ ___

_____ ___ ___ ___ ___ ___

_____ ___ ___ ___ ___ ___

RECOMMENDATIONS

☐ Full physical activity ☐ Full diet

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

MEDICATIONS *(attach MAF if in-school medication needed)*

☐ None ☐ Yes (list below)

_____

_____

DIETARY RESTRICTIONS

☐ **None** ☐ **Yes (list below)**

_____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in the activities of the Boys & Girls Club of Mount Vernon except as noted above.

Please be sure this form has been stamped and dated.

Signature, Examining Physician | Print Name | Date of Examination

Address | City | State | Zip | Phone