#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

☐ Speech, hearing, or visual impairment

☐ Speech, hearing, or visual impairment

☐ Diabetes *(attach MAF)*

☐ Seizure disorder

☐ **Other** *(specify)* _____

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

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s):

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

<u>Explain all checked items above on an addendum</u>

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

<u>Describe Abnormalities on addendum</u>

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