61830 Sandy Ridge Road, Barnesville, OH 43713

www.olneyfriends.org

**PHYSICAL EXAMINATION AND HEALTH HISTORY**

(To be completed by the student's physician)

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_BP \_\_\_\_\_\_\_ Pulse\_\_\_\_\_ Vision: Right 20/\_\_\_\_\_\_\_ Left 20/\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| MEDICAL FINDINGS | NORMAL | ABNORMAL |
| Appearance |  |  |
| Eyes/ears/nose/throat |  |  |
| Hearing |  |  |
| Nodes |  |  |
| Heart |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Neurologic |  |  |
| Extremities |  |  |

MANDATORY: Mantoux TB test ( Must be done prior to arrival at OFS)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: Positive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Negative\_\_\_\_\_\_\_\_\_\_\_\_

If student is a positive reactor for the FIRST time a chest X-ray must be done according to Ohio law.

Date of Chest X-ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If student is a known positive reactor or has a documented history of TB, then the student must be assessed for signs/symptoms

of TB. Please indicate if student is symptom free: Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_

If no, please list symptoms and treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT HEALTH CONDITIONS:

\_\_\_\_\_\_NO Medical Conditions

\_\_\_\_\_YES, this student has a history of/receives care for the following:(Check all that apply)

\_\_\_\_ Allergies \_\_\_\_ Asthma \_\_\_\_\_ADD/ADHD \_\_\_\_Autism \_\_\_\_\_ Behavior concerns

\_\_\_\_Birth/congenital malformations \_\_\_\_\_Cancer \_\_\_ Diabetes \_\_\_\_Depression

\_\_\_\_Ear problem/difficulty hearing \_\_\_\_\_Emotional concerns \_\_\_\_\_Headaches

\_\_\_\_Heart problems \_\_\_\_Hemophilia \_\_\_\_Juvenile arthritis \_\_\_\_\_ Migraines

\_\_\_\_Neuromuscular disorder \_\_\_Seizure disorder \_\_\_\_Skin conditions \_\_\_\_\_ Speech problems

\_\_\_\_Blood disorders \_\_\_\_\_\_Vision problems(glasses,contacts) \_\_\_\_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_Other

Please explain any conditions checked above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is student able to participate fully in:

1) Classroom and academic activities: \_\_\_\_\_\_Yes \_\_\_\_\_No

2) Physical education classes: \_\_\_\_\_Yes \_\_\_\_\_\_No

3)Competition/contact/collision sports: \_\_\_\_Yes \_\_\_\_\_\_ No

If limitations are advised, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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