pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME:

pennsylvania
DEPARTMENT OF HEALTH

Ofisi ya Mifumo ya Afya ya Jumuiya
Idara ya Afya ya Shule

UCHUNGUZI WA KIMWILI
wa Kibinafsi au wa Shule
WA MWANAFUNZI WA UMRI WA SHULE

MZAZI / MLEZI / MWANAFUNZI:

Jaza ukurasa wa kwanza wa fomu hii kabla ya mtihani wa mwanafunzi. Beba fomu iliyojazwa kwa miadi.

Jina la mwanafunzi_____ Tarehe ya leo_____

Tarehe ya kuzaliwa _____ Umri wakati wa uchunguzi_____ Jinsia: ☐ Mwanaume ☐ Mwanamke

Dawa na Mizio: Tafadhali orodhesha dawa za kuagizwa na daktari na dawa za kwenye kaunta (mitishamba/lishe) ambazo mwanafunzi anatumia kwa sasa:

_____

Je, mwanafunzi ana mizio yoyote? ☐ La ☐ Ndiyo (Ikiwa ni ndiyo, orodhesha mzio na athari

☐ Madawa ☐ Mchavusho ☐ Chakula ☐ Wadudu wanaouma

Kamilisha sehemu ifuatayo ukitumia alama ya tiki katika safu ya NDIYO au LA; weka mviringo kwa maswali ambayo hujui jibu lake.

AFYA YA JUMLA: *Mwanafunzi...*	NDIYO	LA
1. Kuna hali zozote za kimatibabu zinazoendelea? Ikiwa ndiyo, tafadhali tambulisha: ☐ Pumu ☐ Anemia ☐ Ugonjwa wa kisukari ☐ Infection Nyingine_____		
2. Amewahi kukaa zaidi ya usiku mmoja hospitalini?		
3. Amewahi kufanyiwa upasuaji?		
4. Amewahi kupata kifafa?		
5. Amekuwa na historia ya kuzaliwa bila au kukosa figo, jicho, kende (wanaume), wengu, au kiungo chochote?		
6. Amewahi kuwa mgonjwa unapofanya mazoezi kwenye joto?		
7. Amepata mipindo ya misuli ya mara kwa mara anapofanya mazoezi?		
KICHWA/SHINGO/UTI: *Mwanafunzi...*	**NDIYO**	**LA**
8. Amepata maumivu ya kichwa akifanya mazoezi?		
9. Amewahi kupata jeraha la kichwa au jeraha la bongo?		
10. Amewahi kupigwa kichwani na kusababisha kuchanganyikiwa, maumivu ya kichwa kwa muda mrefu, au matatizo ya kumbukumbu?		
11. Amewahi kufa ganzi, kuwashwa, au kuwa mdhaifu kwenye mikono au miguu yake baada ya kupigwa au kuanguka?		
12. Amewahi kushindwa kusogeza mikono au miguu baada ya kugongwa au kuanguka?		
13. Ameona au kuambiwa ana mgongo uliopindika?		
14. Alikuwa na tatizo lolote kwenye macho yake au alikuwa na historia ya jeraha la jicho?		
15. Ameagizwa miwani au lensi za macho?		
MOYO/MAPAFU: *Mwanafunzi...*	**NDIYO**	**LA**
16. Amewahi kutumia kivutia hewa au dawa ya pumu?		
17. Amewahi kuambiwa na daktari kwamba ana tatizo la moyo? Ikiwa ndiyo, weka alama kwa zote zinazotumika: ☐ Mapigo yasio ya kawaida ya moyo au maambukizo ya moyo ☐ Shinikizo la juu la damu ☐ Ugongwa wa Kawasaki ☐ Kolesteroli ya juu ☐ Nyingine:_____		
18. Ameambiwa na daktari afanyiwe uchunguzi wa moyo? (Kwa mfano, ECG/EKG, echocardiogram)?		
19. Alikuwa na kikohozi, kuforota, kupumua kwa shida, kushindwa kupumua au kuhisi kichefuchefu WAKATI au BAADA ya mazoezi?		
20. Alikuwa anahisi vibaya, maumivu, kifua kubana au shinikizo la kifua anapofanya mazoezi?		
21. Alihisi mapigo ya moyo kwenda mbio au mapigo kuruka anapofanya mazoezi?		
MFUPA/KIUNGO: *Mwanafunzi...*	**NDIYO**	**LA**
22. Alikuwa na mfupa uliovunjika, kuvunjika kwa ajili ya mkazo, au kiungo kilichoteguka?		
23. Alikuwa na jeraha kwa misuli au kano?		
24. Alikuwa na jeraha ambalo lilihitaji vifaa vya kutegemeza meno, mikongojo, magongo au vifaa vya mifupa?		
25. Alihitaji uchunguzi wa eksirei, MRI, CT, sindano, au matibabu ya kimwili kufuatia jeraha?		
26. Alikuwa na viungo ambavyo vinauma, kuvimba, kuhisi joto au kuonekana kuwa mekundu?		
NGOZI: *Mwanafunzi...*	**NDIYO**	**LA**
27. Alikuwa na vipele, vidonda vya shinikizo, au matatizo mengine ya ngozi?		
28. Amewahi kuwa na ugonjwa wa malengelenge au ugonjwa wa ngozi wa MRSA?		

VIUNGO VYA UZAZI: *Mwanafunzi...*	NDIYO	LA
29. Alikuwa na maumivu ya kinena au uvimbe unaouma au ngiri kwenye eneo la kinena?		
30. Alikuwa na historia ya maambukizi ya mfumo wa mkojo au kukojoa kitandani?		
31. WANAWAKE PEKEE: Amewahi kupata hedhi? ☐ Ndiyo ☐ La Ikiwa ndiyo: Alipata hedhi yake akiwa na umri gani? _____ Amepata hedhi ngapi katika miezi 12 iliyopita? _____ Tarehe ya hedhi ya mwisho. _____		
MENO:	**NDIYO**	**LA**
32. Mwanafunzi amekuwa na maumivu au matatizo yoyote kwenye fizi au meno yake?		
33. Jina la daktari wa meno wa mwanafunzi: _____ Ziara ya mwisho ya matibabu ya meno: ☐ Chini ya mwaka 1 ☐ mwaka 1-2 ☐ zaidi ya miaka 2		
KIJAMII/KUSOMA: *Mwanafunzi...*	**NDIYO**	**LA**
34. Amewahi kuambiwa ana ulemavu wa kusoma, ulemavu wa kiakili au ukuaji, kuchelewa kiakili, ADD/ADHD, n.k.?		
35. Amewahi kuonewa au umekumbwa na tabia ya uonevu?		
36. Amepitia huzuni kuu, kiwewe au tukio lingine muhimu la maisha?		
37. Alionyesha mabadiliko makubwa katika tabia, mahusiano ya kijamii, gredi, tabia ya kula au kulala; kujitenga na familia au marafiki?		
38. Amekuwa na wasiwasi, huzuni, kuudhika, au hasira muda mwingi?		
39. Je, umeonyesha kukosa nguvu, motisha, raghba au shauku kwa jumla?		
40. Amekuwa na wasiwasi kuhusu uzito; amekuwa akijaribu kuongeza au kupunguza uzito au kupokea mapendekezo ya kuongeza au kupunguza uzito?		
41. Alitumia (au anatumia sasa) tumbaku, pombe au dawa za kulevya?		
AFYA YA FAMILIA:	**NDIYO**	**LA**
42. Je, kuna historia ya familia ya mambo yafuatayo? Ikiwa ndiyo, weka alama kwa zote zinazotumika: ☐ Anemia/matatizo ya damu ☐ Ugonjwa wa kurithi ☐ Matatizo ya pumu/mapafu ☐ Matatizo ya figo ☐ Tatizo la afya ya tabia ☐ Ugonjwa wa kifafa ☐ Kisukari ☐ Aina ya ugonjwa wa seli mundu Nyingine_____		
43. Je, kuna historia ya familia ya matatizo yoyote kati ya yafuatayo yanayohusiana na moyo? Ikiwa ndiyo, weka alama kwa zote zinazotumika: ☐ Ugonjwa wa Brugada ☐ Ugonjwa wa QT ☐ Cardiomyopathy ☐ Ugonjwa wa Marfan ☐ Shinikizo la juu la damu ☐ Ventricular tachycardia ☐ Kolesteroli ya juu ☐ Nyingine_____		
44. Je, kuna mwanafamilia yeyote ambaye amezimia bila sababu, kifafa kisichoelezeka, au alikaribia kuzama?		
45. Je, kuna mwanafamilia/jamaa yeyote aliyefariki kwa ajili ya matatizo ya moyo kabla ya umri wa miaka 50 au alikufa kwa ghafla kisichotarajiwa/kisichojulikana kabla ya umri wa miaka 50 (pamoja na kuzama majini, ajali za gari zisizoelezeka, ugonjwa wa kifo cha ghafla cha watoto wachanga)?		
MASWALI AU HOJA	**NDIYO**	**LA**
46. Je, kuna maswali au hoja zozote ambazo mwanafunzi, mzazi au mlezi angependa kujadiliana na mhudumu wa afya? (Ikiwa ndiyo, ziandike kwenye ukurasa wa 4 wa fomu hii.)		

Ninathibitisha kwamba kadri ya ufahamu wangu, maelezo yote ni ya kweli na kamili. Ninatoa idhini yangu ya kubadilishana maelezo ya afya kati ya muuguzi wa shule na watoa huduma za afya.

Saini ya mzazi / mlezi / mwanafunzi aliyeachiliwa_____ Tarehe_____

Sehemu imetolewa kwa *Fomu ya Historia ya Tathmini ya Kimwili ya Kabla ya Kushiriki*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, na American Osteopathic Academy of Sports Medicine.

HISTORIA YA AFYA YA MWANAFUNZI (ukurasa wa 1 wa fomu hii) IMEKAGULIWA KABLA YA KUFANYA UCHUNGUZI: Ndiyo ☐ La ☐				
Uchunguzi wa kimwili wa darasa la: K/1 ☐ 6 ☐ 11 ☐ Nyingine ☐	WEKA TIKI KWA MOJA			*MATOKEO YASIYO YA KAWAIDA / MAPENDEKEZO / RUFAA
	KAWAIDA	*SIO YA KAWAIDA	AHIRISHA	
Urefu: ( ) inchi				
Uzito: ( ) ratili				
BMI: ( )				
BMI-ya Asilimia ya Umri: ( ) %				
Mapigo ya moyo: ( )				
Shinikizo la Damu: (/)				
Nywele/Ngozi ya Kichwa				
Ngozi				
Macho Yamerekebishwa ☐				
Masikio				
Pua na Koo				
Meno na Sini				
Tezi Limfu				
Moyo				
Mapafu				
Tumbo				
Viungo vya Uzazi:				
Mfumo wa Misulinuroli				
Magonjwa Kali				
Uti wa mgongo (mgongo ulipindika)				
Nyingine				

VIPIMO VYA TUBERCULIN	TAREHE ILITUMIKA	TAREHE ILISOMWA	MATOKEO/UFUATILIA-JI

HALI ZA KIMATIBABU AU MAGONJWA SUGU YANAYOHITAJI MATIBABU, UZUIZI WA KUFANYA SHUGHULI, AU AMBAYO INAWEZA KUATHIRI ELIMU
(Nafasi ya ziada kwenye

Mzazi/mlezi kuwepo wakati wa uchunguzi: ☐ **La** ☐

Uchunguzi wa kimwili unafanywa katika: Ofisi ya Mtoa Huduma za Afya wa Kibinafsi ☐ **Shule** ☐
Tarehe ya uchunguzI_____20_____

Andika jina la mchunguzi _____

Andika anwani ya ofisi ya mchunguzi_____**Simu**_____

Saini ya mchunguzi_____**MD** ☐ **DO** ☐ **PAC** ☐ **CRNP** ☐

 JINA LA MWANAFUNZI:

WATOA HUDUMA YA AFYA: ***Tafadhali toa nakala ya historia ya chanjo kutoka kwa rekodi ya mwanafunzi – AU – weka maelezo hapa chini.***

RUHUSA ZA CHANJO:

Matibabu ☐ Tarehe Ilitolewa:_____Sababu:_____Tarehe Ilibatilishwa:_____

Matibabu ☐ Tarehe Ilitolewa:_____Sababu:_____Tarehe Ilibatilishwa:_____

Matibabu ☐ Tarehe Ilitolewa:_____Sababu:_____Tarehe Ilibatilishwa:_____

KUMBUKA: Lazima mzazi/mlezi atoe ombi lililoandikwa kwa shule la ruhusa kwa ajili ya kidini au wa kifalsafa.

CHANJO	HATI: (1) Aina ya chanjo; (2) Tarehe (mwezi/siku/mwaka) ya kila chanjo				
Aina ya Diphtheria/Pepopunda/Pertussis (mtoto): DTaP, DTP au DT	1	2	3	4	5
Aina Diphtheria/Pepopunda/Pertussis (kijana/mtu mzima) Aina: Tdap au Td	1	2	3	4	5
Polio Aina: OPV au IPV	1	2	3	4	5
Ugonjwa wa Ini (Hep B)	1	2	3	4	5
Ukambi/Matumbwitumbwi/Rubela (MMR)	1	2	3	4	5
Ugonjwa wa matumbwitumbwi uliotambuliwa na daktari ☐	Tarehe:_____				
Varicella: Chanjo ☐ Ugonjwa ☐	1	2	3	4	5
Seroloji: (Tambua Antijeni/Tarehe/POS au NEG) yaani Hep B, Ukambi, Rubella, Varicella	1	2	3	4	5
Chanjo ya Meningococcal Conjugate (MCV4)	1	2	3	4	5
Aina ya Virusi vya Human Papilloma (HPV): HPV2 au HPV4	1	2	3	4	5
Mafua Aina: TIV (hudungwa) LAIV (puani)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Aina ya B ya Haemophilus influenzae (Hib)	1	2	3	4	5
Aina ya Chanjo ya Pneumococcal Conjugate (PCV): 7 au 13	1	2	3	4	5
Homa ya manjano (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Chanjo Zingine: (Aina na Tarehe)					

Ukurasa wa 4 kati ya 4: MAONI YA JUMLA (MZAZI / MLEZI / MWANAFUNZI / MTOA HUDUMA YAAFYA) JINA LA MWANAFUNZI: