

# REQUIRED PAUL SMITHS COLLEGE HEALTH EXAMINATION FORM

## TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER

**Note:** Paul Smiths requires a physical exam for new entrants and annually for sports; and working papers as needed; or as required by the Committee on Special Education (CSE)

### STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input checked="" type="checkbox"/> X	
School: PAUL SMITHS COLLEGE		Grade: _____ Exam Date: _____

### HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type:  <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other:  <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type:  <input type="checkbox"/> Medication/Treatment Order Attached Date of last seizure:  <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2  <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

### Diagnoses/Problems (ICD-10)

### PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	COMMUNICABLE DISEASE
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Confirmed free of communicable disease
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

### System Review Within Normal Limits

### Abnormal Findings – List Pertinent Medical Concerns Below

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

Assessment/Abnormalities Noted/Recommendations:

Additional Information Attached

Name:	Affirmed Name (if applicable):			DOB:			
<b>SCREENINGS</b>							
Vision & Hearing Screenings Required							
<b>Vision Screening</b>	<b>With Correction</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/		20/		<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/		20/		<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass		<input type="checkbox"/> Fail			<input type="checkbox"/>
Notes							
Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000, 6000 & 8000 Hz.						<b>Not Done</b>	
Pure Tone Screening		<b>Right</b>	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<b>Left</b>	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
				<b>Referral</b>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
Notes							
Scoliosis Screening:		<b>Negative</b>		<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>	
		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>							
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act <input type="checkbox"/> EKG baseline performed and reviewed <input type="checkbox"/> Student may participate in all activities without restrictions.							
<b>If Restrictions Apply</b> – Complete the information below							
<input type="checkbox"/> Student is restricted from participation in: <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> <b>Other Restrictions:</b>  <input type="checkbox"/> <b>Other Accommodations*:</b> Provide Details							
<b>MEDICATIONS</b>							
<b>IMMUNIZATION Requirements</b>				<b>IMMUNIZATION Recommendations</b>			
<input type="checkbox"/> MMR series <input type="checkbox"/> Hep A series (baking major)				<input type="checkbox"/> Meningitis <input type="checkbox"/> Tdap			
<b>HEALTHCARE PROVIDER</b>							
Healthcare Provider Signature:							
Provider Name: (please print)							
Provider Address:							
Phone:		Fax:					
Please Return This Form to Paul Smiths Health Office when Completed. Fax # (518) 327-6319							