#3: Medical Information/Immunization for Physician

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

General Appearance/Physical Examination

Height _____ ins (___ ___ %ile) Weight _____ lbs (___ ___ %ile)

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):***
  - ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
- ☐ Speech, hearing, or visual impairment
- ☐ Diabetes *(attach MAF)*
- ☐ Seizure disorder
- ☐ **Other** *(specify)* _____

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>

ALLERGIES ☐ None ☐ Epi Pen Prescribed

- ☐ Drugs (list) _____
- ☐ Foods (list) _____
- ☐ Other (list) _____

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions (*specify)* _____

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

☐ Other _____

MEDICATIONS *(attach MAF if medication needed during Club hours)* ☐ None ☐ Yes (list below)

_____

_____

_____

(Over)

DIETARY RESTRICTIONS ☐ **None** ☐ **Yes (list below)**

_____

_____

_____

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**

_____ ___ ___ ___ ___ ___

_____ ___ ___ ___ ___ ___

_____ ___ ___ ___ ___ ___

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 _____

GREAT FUTURES START HERE.