COMMUNITY UNIT SCHOOL DISTRICT

PARKVIEW JR. HIGH

Erica Steffey, RN - School Nurse
618-943-6161

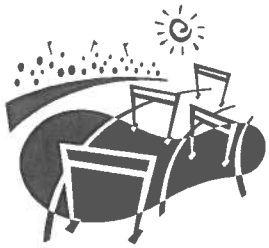
WHO: Lawrence County Memorial Hospital (LCMH) Rural Health Clinic Providers

WHAT: "FREE PHYSICALS" for incoming 9th graders for the 2020-2021 school years. This physical meets the requirements for the 9th grade physical.

WHEN: ***TO BE ANNOUNCED***-physical completed during the school day

WHERE: Parkview Jr. High

COST: ***FREE***



LCHM is coming to PJHS to do **FREE** physicals.
In order for your student to receive this free physical you must:

1. Complete and sign the "Health History" (the top portion of the attached physical form). Answer allergies and medication questions
2. Complete and sign LCMH consent form
3. Completed forms must be returned to the school nurse office by _____

A parent/guardian ***is not required*** to be present at time of physical.

REMINDER:

- _____ **-Deadline for the required forms listed above. If forms are not completed and signed by parent or guardian the physical will not be performed.**
- **Physical Date: _____-During the school day**

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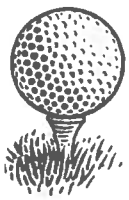

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:

Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes	No		**Parent/Guardian Signature**			**Date**

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____
Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

COMMUNITY UNIT SCHOOL DISTRICT #20
1802 Cedar Street
Lawrenceville, IL 62439

RETURN THIS TOP FORM TO SCHOOL NURSE BY

_____

Requirements for entry into the 9th grade

Student's name:_____
Notification Initial date:_____
Second date:_____
Mailed date:_____

Dear Parent or Guardian:
To be certain that a parent or guardian received the attached letter the student is required to have THIS FORM signed below and returned to the school nurse.

THIS FORM IS DUE BY

I have received notice that my student must provide proof of the following before he/she may begin school next school year.

Certificate of Child Health Examination

THERE ARE **2** OPTIONS

Sign only one option

My child will have his/her school physical completed by their Health Care Provider. Completed physical is due by _____
Have your health care provider complete the attached physical form and return to the school nurse.

Signature of parent/guardian:_____

OR

My student will have their physical completed on the "Free Physical Day" at Parkview Junior High on _____See the attached forms for more information. The completed forms are due by _____.

Signature of parent/guardian_____