COMMUNITY UNIT SCHOOL DISTRICT #20

LAWRENCEVILLE HIGH SCHOOL

Erica Steffey, RN - School Nurse

618-943-6161

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

WHAT: "FREE Athletic Physicals" for 2020-2021 school year

WHEN: TO BE ANNOUNCED-to do during the school day

WHERE: Lawrenceville High School

COST: FREE

In order for your athlete to receive this free physical at school you must:

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

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**

LAWRENCE COUNTY
MEMORIAL HOSPITAL

PRIMARY CARE CLINIC

I, _____, parent or legal guardian of

_____give my permission for a provider of the Lawrence County Memorial Hospital Primary Care Clinic to perform on my child a physical at the school.

Date_____

_____

Signature of parent or legal guardian