



Physical Examination Form

Return form by June 30, 2010 to: HPA Enrollment, 65-1692 Kohala Mountain Road, Kamuela, Hawai'i 96743 -or- Fax: 808-881-4045

INSTRUCTIONS

- **New Students:** All new students are required to have a physical exam done within one year of school entry. This physical exam must be performed and the entire form completed by a U.S. licensed medical doctor (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or physician assistant (PA).
- **Returning Students:** Physical examinations are required of returning students entering grades 3, 6, 9, 10, 11, 12, and post graduate year. Returning students may have their physical exams completed by physicians licensed in other countries.
- **Athletic Participation:** This form is required for athletic participation.
- **Students with religious exemption** are required to submit a religious exemption form.

HPA may delay class entry to a student who has not met all the health requirements by the first day of school.

STUDENT INFORMATION

Student name: _____ Date of birth: _____ Grade: _____

HEALTH HISTORY

Height (in): _____ Weight (lbs): _____ Vision - RT: _____ LT: _____

Blood Pressure: _____ Resting Pulse: _____ Hearing - RT: _____ LT: _____

Tuberculosis (TB) Test - A TB test is required of all new students. Students returning from an area of high TB prevalence may be re-tested by school health staff upon their return to school. A chest x-ray is required if PPD result is >10 mm. A TB test for a new student must be completed by a US licensed qualified personnel or the test will be redone when the student arrives at school.

PPD - Date given: _____ Date read: _____ Result (mm): _____ X-ray date: _____ Results: _____

BCG - No Yes Date: _____

Illnesses - Mark all that apply and indicate date of occurrence(s).

- | | | |
|---|---|---|
| <input type="checkbox"/> Chicken Pox: _____ | <input type="checkbox"/> Concussion: _____ | <input type="checkbox"/> Diabetes: _____ |
| <input type="checkbox"/> Measles: _____ | <input type="checkbox"/> Epilepsy: _____ | <input type="checkbox"/> Anemia: _____ |
| <input type="checkbox"/> Mumps: _____ | <input type="checkbox"/> Depression: _____ | <input type="checkbox"/> Eating Disorder: _____ |
| <input type="checkbox"/> Rubella: _____ | <input type="checkbox"/> Mononucleosis: _____ | <input type="checkbox"/> STI: _____ |
| <input type="checkbox"/> Poliomyelitis: _____ | <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Dizziness or syncope during or after exercise: _____ |
| <input type="checkbox"/> Diphtheria: _____ | <input type="checkbox"/> Eczema: _____ | <input type="checkbox"/> Chest pain during or after exercise: _____ |
| <input type="checkbox"/> Whooping Cough: _____ | <input type="checkbox"/> Heart Condition: _____ | |
| <input type="checkbox"/> Rheumatic Fever: _____ | <input type="checkbox"/> High Blood Pressure: _____ | |
| <input type="checkbox"/> Typhoid Fever: _____ | <input type="checkbox"/> Hepatitis: _____ | |

Injuries - Mark all that apply and indicate date of occurrence(s) and location of injury(ies).

- | | |
|---|--|
| <input type="checkbox"/> Injuries: _____ | <input type="checkbox"/> Dislocations: _____ |
| <input type="checkbox"/> Fractures: _____ | <input type="checkbox"/> Swelling: _____ |
| <input type="checkbox"/> Sprains: _____ | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Strains: _____ | |

Hospitalizations - List dates and reasons: _____

Family history of heart disease or sudden death before age 50 - explain: _____

Clinical Findings

- | | |
|--------------------------|-------------------------|
| Posture/gait: _____ | Groin/genitals: _____ |
| Skin, hair, scalp: _____ | Anus/rectum: _____ |
| EENT: _____ | Back/extremities: _____ |
| Teeth/mouth: _____ | Glands: _____ |
| Neck/thyroid: _____ | Neurological: _____ |
| Heart: _____ | Psycho-social: _____ |
| Lungs/chest: _____ | Nutrition: _____ |
| Abdomen: _____ | Menses: _____ |

- CONTINUED ON PAGE 2 -

Student's Name: _____ Grade: _____

REQUIRED IMMUNIZATIONS for school entry in Hawai'i - Kindergarten-Grade 12. Required minimum intervals between vaccine doses must be observed. A copy of an immunization record may be attached. This record must be signed by a U.S. licensed medical doctor (MD), doctor of osteopathy (OD), advanced practice registered nurse (APRN), or physician assistant (PA), and must be in English or accompanied with an English translation.

Vaccine # of Doses Vaccine Abbreviations

- DTP or DTaP 5 DTP=Diphtheria-Tetanus-Pertussis; DTaP=Diphtheria-Tetanus-acellular Pertussis
- Polio 4 Polio=OPV or IPV; OPV=Oral Polio Vaccine; IPV=Inactivated Polio Vaccine
- MMR 2 MMR=Measles-Mumps-Rubella (Two doses of measles required with at least one being MMR)
- Hepatitis B 3 Hep B=Hepatitis B (Required for school entry for all students born after December 31, 1992)
- Varicella 1-2 Chicken Pox (Required for all new students with no history of chicken pox disease, and for any student entering grade 7 with no history of chicken pox disease. Two doses required if first dose given on or after 13th birthday.)
- Meningococcus Recommended. Please discuss with your primary care physician for his/her recommendation.

IMMUNIZATIONS - Please list complete history from birth.

	- B A S I C -			- B O O S T E R -		
	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
Diphtheria						
Tetanus						
Pertussis						
Polio						
Varicella						

	- B A S I C -		
	M/D/Y	M/D/Y	M/D/Y
Mumps			
Measles			
Rubella			
Hepatitis A			
Hepatitis B			
Meningococcus			

OTHER CONCERNS

Any health conditions that should be called to our attention (e.g. allergies, medications): _____

Physical restrictions/reasons: _____

Sports/PE restrictions/reasons: _____

Diet restrictions/reasons: _____

Recommendations for modified physical activity programs: _____

Additional Notes/Comments: _____

PHYSICIAN INFORMATION

Signature of examiner: _____ Print name: _____

Address: _____ U.S. license #: _____

Phone: _____ Fax: _____ Date of exam: _____