

CLASSROOM MANAGEMENT

**SHAPE INTERNATIONAL SCHOOL CANADIAN SECTION
MEDICAL EXAM / SCHOOL HEALTH RECORD**



(Date)

All new incoming students to the Canadian Section must have a complete medical examination done before school begins.

Please schedule your appointment now to avoid school restrictions.

Principal
Canadian Section

**INFANT, CHILD AND ADOLESCENT HEALTH
ASSESSMENT**

DATA REQUIRED BY THE PRIVACY ACT 1994

AUTHORITY: Title 10, United States Code, Section 3012. PRINCIPAL PURPOSE: information is used by DA personnel to: (1) verify child health and currency of immunizations per admission requirements; (2) note special program consideration; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollement in Exceptional Family Member Program. ROUTINE USES; No information is disclosed outside DoD. DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in community activity programs

NAME OF SPONSOR:	DEROS:	TELEPHONE (HOME):	TELEPHONE (DUTY):
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SPONSOR'S UNIT ADDRESS:	SPONSOR'S SSN:	SPOUSE'S WORK PHONE:
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CHILD HEALTH INFORMATION (SPONSOR)

NAME OF CHILD:	BIRTH DATE:	SEX:
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HAS YOUR CHILD EVER BEEN UNDER THE SUPERVISION OF A PHYSICIAN? (IF YES, EXPLAIN THE CIRCUMSTANCES AND CURRENT STATUS)

IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM? NO/YES LAST UPDATE:

IMMUNIZATIONS – Valid ONLY when completed, signed and stamped by a MEDICAL PROFESSIONAL!

	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						TdaP
HIB						TD
POLIO						PPD
HEP B				INFLUENZA		
MMR			HEP A			
VARICELLA			MCV4(Menactra)			

MEDICAL HISTORY

	YES	NO		YES	NO
1. ANY HOSPITALIZATION OR OPERATIONS			14. HEAT STROKE OR EXHAUSTION		
2. ALLERGIES TO MEDICINE OR INSECT BITES			15. BROKEN BONES OR SPRAINS		
3. SPEECH OR DEVELOPMENTAL DELAYS			16. JOINT INJURIES (ANKLE/KNEE/WRIST)		
4. VISION PROBLEMS (GLASSES/CONTACTS)			17. REQUIRED RESTRICTED PHYSICAL ACTIVITY		
5. EAR OR HEARING PROBLEMS			18. FAMILY HISTORY OF DEATH LESS THAN AGE 40		
6. SEIZURES OR CONVULSIONS			19. FAMILY HX OF HEART DISEASE/STROKE<AGE 50		
7. DIZZINESS OR FAINTING WITH EXERCISE			20. FAMILY HX OF HIGH CHOLESTOROL		
8. HEADACHES			21. FMAILY HX OF CANCER		
9. HEAD INJURY OR LOSS OF CONCIIOUSNESS			22. DENTAL OR ORTHODONTIC BRACE		
10. NECK OR BACK INJURY			23. CHICKEN POX (IF YES, DATE:)		
11. ASTHMA OR DIFFICULTY BREATHING			24. ROUTINE OR DAILY MEDICATIONS (LIST BELOW)		
12. HEART OR BLOOD PRESSURE PROBLEMS			25. FEMALES: AGE OF FIRST PERIOD		
13. CHEST PAIN WITH EXERCISE			26. OTHER PROBLEMS (LIST BELOW)		

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

I GIVE MY PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE: YES NO

1. RECEIVE A PPD (SKIN TEST FOR TUBERCULOSIS)		
2. RECEIVE ANY IMMUNIZATION(S) NECESSARY		
3. RECEIVE A HEALTH SCREENING EXAMINATION FOR SPORTS / SCHOOL / SCHOUTS / CDS / OTHER		
4. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CDS		

TYPED OR PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN
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MEDICAL STAFF ASSESSEMENT					
AGE: YRS, MOS	HEIGHT: cm.(%ile) HEIGHT: in.	WEIGHT: Kgs.(%ile) WEIGHT: lbs.	BP: / P:		
VISUAL ACUITY RIGHT: / LEFT: /	TESTED WITH/WITHOUT LENSES	NORMAL		ABNORMAL	
	NORMAL	ABNORMAL	N/A	COMMENTS	
1. EYES					
2. EARS, NOSE & THROAT					
3. HEARING					
4. MOUTH AND TEETH					
5. NECK (SOFT TISSUE)					
6. CARDIOVASCULAR					
7. CHEST AND LUNGS					
8. ABDOMEN					
9. GENITALIA – HERNIA					
10. SKIN AND LYMPHATICS					
11. NECK					
12. SPINE – SCOLIOSIS					
13. EXTREMITIES					
14. NEUROLOGICAL					
15. SEXUAL MATURITY RATING: BREASTS> PUBIC HAIR> MALE GENITAL> FEMALE GENITAL>					
BASED ON THIS HISTORY & PHYSICAL EXAM, THE FOLLOWING ABNORMALITIES WERE FOUND AND MAY NEED TREATMENT:					
ANTICIPATORY GUIDANCE (CHECK ITEMS DISCUSSED)					
NUTRITION	DENTAL				
AGE APPROPRIATE SAFETY	BEHAVIOR				
DEVELOPMENT	RISK FACTOR				
PARTICIPATION RECOMMENDATIONS					
NORMAL SCHOOL ACTIVITIES			CONTACT SPORTS		
CHILD DEVELOPMENT / YOUTH SERVICES			NON-CONTACT SPORTS		
COLLISION SPORTS			SCOUTS		
THIS STUDENT HAS HEALTH PROBLEMS WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS :					
NO YES					
THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:					
THIS DOCUMENT IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW					
DATE:	PHYSICIAN'S STAMP		PHYSICIAN'S SIGNATURE		