# Hawthorn School District 73

841 West End Court, Vernon Hills, Illinois 60061
Phone (847) 990-4200 / Fax (847) 367-3290
www.hawthorn73.org

The State of Illinois requires that schools have the following health documents on file for your child. These documents require the signature of a doctor and parent. **Please be advised that students who have not provided the required health forms prior to October 15th will be excluded from school in accordance with Illinois law. If enrolling after October 15th, compliance is required within 30 calendar days.** Forms may be downloaded on the district website, www. http://hawthorn73.org/health. Please keep copies for your files.

## Students Enrolling in an Illinois School for the First Time:

- Illinois Certificate of Child Health Exam/Immunization Record (dated within one year or less)
- Illinois Eye Exam Report
- Illinois Proof of Dental Examination

* For participation in extracurricular athletics provided through the Middle Schools:

- IHSA/IESA Pre-Participation Examination (Note: The sports physical is due prior to the try-out date.)

## Students Transferring from Another Illinois Public School or Returning to Illinois:

- IL Certificate of Child Health Exam/Immunization Record (dated within one year or less)

If entering Kindergarten:

- IL Eye Exam Report

If entering Kindergarten, Grade 2 or Grade 6:

- IL Proof of Dental Examination

* For participation in extracurricular athletics provided through the Middle Schools:

- IHSA/IESA Pre-Participation Examination (Note: The sports physical is due prior to the try-out date.)

## Students Entering Kindergarten:

- IL Certificate of Child Health Exam/Immunization Record (dated within one year or less)
- Childhood Lead Risk Assessment Questionnaire
- IL Eye Exam Report
- IL Proof of Dental Exam

## Continuing Hawthorn Students Must Provide:

*If entering Grade 2 or 6*:

- IL Proof of Dental Examination

*If entering Grade 6*:

- IL Certificate of Child Health Exam/Immunization Form
- Proof of Tdap vaccination
- Proof of one meningococcal conjugate vaccine (MCV4) given on or after their 10th birthday.

*If entering Grade 7 or 8*:

- Has completed the immunizations required for the 6th grade level.

* For participation in extracurricular athletics provided through the Middle Schools:

- IHSA/IESA Pre-Participation Examination (Note: The sports physical is due prior to the try-out date.)

Students with specific health concerns should alert their school nurse and complete the appropriate health management forms, which are available at www.hawthorn73.org/health or from your school nurse.

**Hawthorn Registered Nurses:**

Elementary North: Lisa Frazier-Sweeney, 847-990-4514
Elementary South: Francie Mundrane, 847-990-4815
Aspen Elementary: Roni Weiss, 847-990-4314
Lincoln School: Deb Geib, 847-990-1676
Townline Elementary: Dena Mahrenholz 847-990-4915
School of Dual Language: Megan Copeland, 847-990-4914
Hawthorn Middle School South: Lora Jacobs, 847-990-4118
Hawthorn Middle School North: Janet Howard, 847-990-4415

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>Month/Day/Year | Sex | Race/Ethnicity | School /Grade Level/ID# |
|---|---|---|---|---|
| Address Street City Zip Code | Parent/Guardian | Telephone # Home | | Work |

**IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

| REQUIRED Vaccine / Dose | DOSE 1 MO DA YR | DOSE 2 MO DA YR | DOSE 3 MO DA YR | DOSE 4 MO DA YR | DOSE 5 MO DA YR | DOSE 6 MO DA YR |
|---|---|---|---|---|---|---|
| **DTP** or **DTaP** | | | | | | |
| **Tdap**; **Td** or Pediatric **DT** (Check specific type) | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT |
| **Polio** (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV |
| **Hib** Haemophilus influenza type b | | | | | | |
| **Pneumococcal Conjugate** | | | | | | |
| **Hepatitis B** | | | | | | |
| **MMR** Measles Mumps. Rubella | | | | | | |
| **Varicella** (Chickenpox) | | | | | | |
| **Meningococcal conjugate (MCV4)** | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose** | | | | | | |
| **Hepatitis A** | | | | | | |
| **HPV** | | | | | | |
| **Influenza** | | | | | | |
| **Other: Specify Immunization Administered/Dates** | | | | | | |

**Comments:**

**Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.**
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

**Signature** **Title** **Date**

**Signature** **Title** **Date**

**ALTERNATIVE PROOF OF IMMUNITY**

**1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.**
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

**2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
**Date of Disease** **Signature** **Title**

**3. Laboratory Evidence of Immunity (check one)** ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

**Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.**

| 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. **Parent/Guardian Signature** | | **Date** | |
| Bone/Joint problem/injury/scoliosis? | Yes No | | | | | | |

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

**HEAD CIRCUMFERENCE if < 2-3 years old** **HEIGHT** **WEIGHT** **BMI** **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**

# State of Illinois
# Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ (Month/Day/Year) Gender _____ Grade _____

Parent or Guardian _____ (Last) _____ (First)

Phone _____ (Area Code)

Address _____ (Number) (Street) (City) (ZIP Code)

County _____

**To Be Completed By Examining Doctor**

**Case History**

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

**Examination**

| | Distance | | | Near |
|---|---|---|---|---|
| | Right | Left | Both | Both |
| Uncorrected visual acuity | 20/ | 20/ | 20/ | 20/ |
| Best corrected visual acuity | 20/ | 20/ | 20/ | 20/ |

Was refraction performed with dilation? ❑ Yes ❑ No

| | Normal | Abnormal | Not Able to Assess | Comments |
|---|---|---|---|---|
| External exam (lids, lashes, cornea, etc.) | ❑ | ❑ | ❑ | _____ |
| Internal exam (vitreous, lens, fundus, etc.) | ❑ | ❑ | ❑ | _____ |
| Pupillary reflex (pupils) | ❑ | ❑ | ❑ | _____ |
| Binocular function (stereopsis) | ❑ | ❑ | ❑ | _____ |
| Accommodation and vergence | ❑ | ❑ | ❑ | _____ |
| Color vision | ❑ | ❑ | ❑ | _____ |
| Glaucoma evaluation | ❑ | ❑ | ❑ | _____ |
| Oculomotor assessment | ❑ | ❑ | ❑ | _____ |
| Other _____ | ❑ | ❑ | ❑ | _____ |

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

**Diagnosis**

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____



*Continued on back*

# State of Illinois
# Eye Examination Report

**Recommendations**

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____

_____

Phone _____

**Consent of Parent or Guardian**

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____

Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)



Printed by Authority of the State of Illinois
6/09

IOCI1271-09

**State of Illinois**
Illinois Department of Public Health

# PROOF OF SCHOOL DENTAL EXAMINATION FORM

**To be completed by the parent (please print):**

| | | | | |
|---|---|---|---|---|
| Student's Name: Last | First | Middle | | Birth Date: (Month/Day/Year) / / |
| Address: Street | City | ZIP Code | | Telephone: |
| Name of School: | | Grade Level: | | Gender: ☐ Male ☐ Female |
| Parent or Guardian: | | Address (of parent/guardian): | | |

**To be completed by dentist:**

**Oral Health Status (check all that apply)**

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

**Treatment Needs (check all that apply)**

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

# Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name_____ School Year_____
Last First Middle

Address_____ City/State_____

Phone No._____ Birthdate_____ Age_____ Class_____ Student ID No._____

Parent's Name_____ Phone No._____

Address_____ City/State_____

## HISTORY FORM

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Have you or any family member or relative been diagnosed with cancer? | | |
| 52. Do you have any concerns that you would like to discuss with a doctor? | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 53. Have you ever had a menstrual period? | | |
| 54. How old were you when you had your first menstrual period? | | |
| 55. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

**Signature of athlete**_____ **Signature of parent/guardian**_____ **Date**_____

# Pre-participation Examination

**PHYSICAL EXAMINATION FORM**

**Name** _____
Last First Middle

| EXAMINATION | | | |
|---|---|---|---|
| Height Weight | ☐ Male ☐ Female | | |
| BP / ( / ) Pulse | Vision R 20/ L 20/ | Corrected ☐ Y ☐ N | |
| **MEDICAL** | | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | | |
| Lymph nodes | | | |
| Heart [a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only)[b] | | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | | |
| Neurologic [c] | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot/toes | | | |
| Functional<br>• Duck-walk, single leg hop | | | |

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes No Limited Examination Date

Additional Comments:

Physician's Signature Physician's Name

Physician's Assistant Signature* PA's Name

Advanced Nurse Practitioner's Signature* ANP's Name

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.