Physical Examination Form

Applicant's Name: ____ Date: __________________

Date of Birth: _________________ Age at Exam: _____________ Gender: ☐ Male ☐ Female

Primary Diagnosis: ____

Secondary Diagnosis: ____

HEALTH HISTORY: ***Parents/Guardians** please complete the following section with a check mark in the YES or NO column.

GENERAL HEALTH: ***Has the applicant…***	**YES**	**NO**
1. Any ongoing medical conditions such as : ☐ Anemia ☐ Infection ☐ Sores ☐ Allergies ☐ Asthma ☐ Diabetes ☐ Other: ________________________________		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever has a seizure?		
5. Has a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the applicant…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever has a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever has numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problems with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the applicant…***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever has the doctor say he/she has a heart problem, including: ☐ High blood pressure ☐ Heart murmur or heart infection ☐ High cholesterol ☐ Kawasaki disease ☐ Other: __________________________________		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath, or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the applicant…***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		

SKIN: ***Has the applicant…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or MRSA skin infection?		
GENITOURINARY: ***Has the applicant…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY**: Had a menstrual period ☐ YES ☐ NO If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? _______ Date of last period: _______		
DENTAL: ***Has the applicant…***	**YES**	**NO**
32. Has the applicant has any pain or problems with his/her gums or teeth?		
33. Name of applicant's dentist: ________________________________ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the applicant…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experiences bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant change in behavior, social relationships, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest, or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH: ***Has the applicant…***	**YES**	**NO**
42. Is there a family history of the following? (check all that apply) ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease ☐ Other: _________________________________		
43. Is there a family history of any of the following heart-related problems? (check all that apply) ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐High cholesterol ☐ Other: _________________________________		
44. Has any family member has unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		

MEDICATIONS: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the applicant is currently taking. Please indicate when medications are taken with an "X" in the appropriate box, or noting the specific time:

☐ No Medications Drug	Description	Dose	Form	Before Breakfast	Breakfast	Before Lunch	Lunch	Before Dinner	Dinner	Bedtime	Comments

PHYSICAL EXAMINATION: To be completed by a licensed physician.

APPLICANT'S HEALTH HISTORY (page 1 or this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: ☐ Yes ☐ No				
	CHECK ONE			
Date of examination:	NORMAL	***ABNORMAL**	**DEFER**	***ABNORMAL FINDINGS / RECOMMENDATIONS/REFERRALS**
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( )%				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vison Corrected ☐				
Ears/Hearing				
Nose/Throat				
Teeth/Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

****Please attach a full immunization history**

☐ **No Restrictions**	**RESTRICTIONS TO ACTIVITY (MOTION, EXERTION, ETC.)**

☐ **No Dietary Needs**	**DIETARY RESTRICTIONS**

Receives Tube Feeds: ☐ Yes ☐ No Formula Type: ________________ Equipment: ______________________

Schedule: ____

Dietary Restrictions (ex. Low sodium, caffeine-free, gluten free, etc):

ALLERGY AND ANAPHYLAXIS PLAN: To be completed by a licensed physician

☐ **No Allergies** ☐ **Seasonal Allergies Only**	**ALLERGENS**

MILD reaction to the following allergens:____

____

EXTREME reaction to the following allergens:____

____

☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms

☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are present

MEDICATIONS

Epinephrine Brand or Generic: ____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ____

Antihistamine Dose: ______________________________

Other: ____

FOR **ANY** OF THE FOLLOWING **SEVERE SYMPTOMS:**

LUNG	Shortness of breath	Wheezing	Repetitive Cough
HEART	Pale or bluish skin	Faintness Weak Pulse	Dizziness
THROAT	Tight or hoards throat	Trouble breathing or swallowing	
MOUTH	Significant swelling of the tongue or lips		
SKIN	Many hives over body	Widespread redness	
GUT	Repetitive vomiting	Severe Diarrhea	
OTHER	Anxiety Confusion	Feeling something bad is about to happen	

1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
   - Consider giving additional medications following epinephrine:
     - Antihistamine
     - Inhaler (bronchodilator) if wheezing
   - Lay person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side
   - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last does.
   - Alert emergency contacts
   - Transport participant to ER, even if symptoms resolve. Participant should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE	Itchy or runny nose	Sneezing
MOUTH	Itchy Mouth	
SKIN	A few hives	Mild itch
GUT	Mild nausea	
	Discomfort	

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE

FOR **MILD SYMPTOMS** FROM **A SINGLE** SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW

1. Antihistamine may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts
3. Watch closely for changes. If symptoms worsen, give epinephrine.

DIABETES MANAGEMENT PLAN: To be completed by a Parent/Guardian

☐ **No History of Diabetes**	**SIGNS AND SYMPTOMS**

Hypoglycemia:

Participant's Signs/Symptoms:____

If Glucose is: _____________ Treat with: ____

Hyperglycemia:

Participant's Signs/Symptoms:____

If Glucose is: _____________ Treat with: ____

When to contact Parent/Guardian: ____

To be completed by a licensed physician

MEDICATIONS

Rescue Medications (*doses must be locked in)*:

Medication: ____ Dose: _____________________

Use if Glucose is: ____________

DIABETES MANAGEMENT SCHEDULE

Time	Insulin	Form	Dose/Scale	Glucose Check Only	Notes

SEIZURE HISTORY AND TREATMENT PLAN: To be completed by a licensed physician

☐ **No History of Seizures** **SEIZURE INFORMATION**

When was the Participant diagnosed with seizures or epilepsy: ____

Date of last seizure: ____________________________________

Seizure Type	Length	Frequency	Description

Known Triggers: ____

Are there any warning signs and/or behavioral changes before the seizure occurs? ☐ Yes ☐ No

Explain: ____

Have there been any recent changes in seizure patterns? ☐ Yes ☐ No

Explain: ____

Do other illnesses/changes affect the seizures? ☐ Yes ☐ No

Explain: ____

How does the Participant react following a seizure? ____

FIRST AID AND CARE

What basic first aid procedures should be taken when the Participant has a seizure at the Woodlands?

____

____

____

Will the participant need to leave activities following a seizure? ☐ Yes ☐ No

What procedures do you recommend for returning the participant to activities?

____

____

____

Basic Seizure First Aid

- Stay calm & track time
- Keep participant safe
- Do not restrain
- Do not put anything in mouth
- Stay with participant until fully conscious
- Record seizure in incident report

Ford Tonic-Clonic Seizure:

- Protect head
- Keep airway open/watch breathing
- Turn participant to the side

Please describe what constitutes an emergency for the participant.

____

____

____

Has the participant ever been hospitalized for continuous seizures? ☐ Yes ☐ No

Explain:____

____

____

A Seizure is Generally Considered an Emergency When:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Participant has repeated seizures without regaining consciousness
- Participant is injured or has diabetes
- Participant has a first-time seizure
- Participant has breathing difficulties
- Participant has a seizure in water

MEDICATIONS

Does the Participant have a Vagus Nerve Stimulator? ☐ Yes ☐ No

Please describe instructions for appropriate magnet use: ____

Rescue Medications (*doses must be locked in*):

Medication: ____ Dose: ________________

Administration timing/method: ____

Instructions following administration: ____

ASTHMA AUTHORIZATION AND TREATMNT PLAN: To be completed by a licensed physician

☐ No Asthma	KNOWN TRIGGERS						
☐ Exercise	☐ Pet Dander	☐ Mold	☐ Dust	☐ Pollen	☐ Strong Odors	☐ Cold Air	☐ Pests

MEDICATIONS

Asthma Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Exercise Pre-treatment: ☐ Not Required ☐ Before Light Activity ☐ Before Sports/Moderate Activity

Give: Albuterol MDI 90/Xopenex MDI 45 ____ Puffs inhaled (by mouth) ☐ 10-15 min before exercise ☐ with spacer

(circle one) Nebulized Albuterol 2.5 mg/Xopenex 0.63mp ____ Vial inhaled (by mouth) ☐ 10-15 min before exercise ☐ with nebulizer

OTHER: ____

Daily Medications:

CONTROLLER MEDICINE (Dose/Route)	HOW MUCH	HOW OFTEN	WHEN
1. ______________________________	__________ Puffs Inhaled ☐ **with spacer**	__________	**AM/PM**
2. ______________________________	__________ Puffs Inhaled ☐ **with spacer**	__________	**AM/PM**
3. ______________________________	__________ Puffs Inhaled ☐ **with spacer**	__________	**AM/PM**

RESCUE MEDICATIONS

Medication Start/End Date Start: ______/______/______ End: ______/______/______

Give: *(circle one)* Albuterol MDI 90/Xopenex MDI 45 ____ Puffs inhaled (by mouth) ☐ every ____ hours ☐ with spacer

Nebulized Albuterol 2.5 mg/Xopenex 0.63mp ____ Vial inhaled (by mouth) ☐ every ____ hours ☐ with nebulizer

OTHER: ____

*If there is no improvement 20 minutes after taking the Rescue Medication: ______________________________

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN

Side Effect(s) to watch for: Nervousness, Shaking, Palpitations, Headache ____________________ **or** ☐ **None**

Reaction to/or negative interaction with food or drugs: ______________________________ **or** ☐ **None**

Self-Administration Authorization: ☐ This participant **is** capable to safely and properly self-administer medication(s)

OR ☐ This participant **is not** approved to self-administer medication(s)

REQUIRED — PHYSICIAN'S CLEARANCE AND SIGNATURE

Parent/Guardian present during exam: ☐ Yes ☐ No

☐ The participant is cleared to attend programming on site at the Woodlands Foundation

☐ The participant is NOT cleared to attend programming on site at the Woodlands Foundation

I acknowledge that some medical care, including medication distribution, first aid, and diabetes management, may be performed at the Woodlands Foundation by an unlicensed student under the direction and/or supervision of a licensed medical professional, and who is at least 18 years of age and has completed certification in CPR, First Aid, and AED, as well as American Diabetes Association approved training within the previous 12 months from a Licensed Diabetes Educator.

Name of Examiner: ______________________________ Phone:_____________ _______________

Examiner's Office Address: ____

Signature of the Examiner: ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP

REQUIRED — PARENT/GUARDIAN SIGNATURE

☐ I authorize the medication to be administered by a Woodlands personnel as described and directed above

☐ I have administered at least one dose of the medication to the participant without adverse effects

☐ I hereby certify to the best of my knowledge all of the information is true and complete.

☐ I give my consent for the exchange of health information between the Woodlands Foundation Inc. and health care providers.

I acknowledge that some medical care, including medication distribution, first aid, and diabetes management, may be performed at the Woodlands Foundation by an unlicensed student under the direction and/or supervision of a licensed medical professional, and who is at least 18 years of age and has completed certification in CPR, First Aid, and AED, as well as American Diabetes Association approved training within the previous 12 months from a Licensed Diabetes Educator.

Signature of Applicant or Parent/Guardian (if under 18): ______________________________ Date:____________