

Encompass Community For Independent Learning

at Friends Academy

1088 Tucker Road North Dartmouth, MA 02747

Tel. (508) 999-1356 Fax (508) 997-0117

HEALTH QUESTIONNAIRE AND PRACTITIONER'S EXAMINATION 2018-19

***THIS SIDE TO BE FILLED OUT BY PARENTS**

Please return prior to start of program

Name of Student _____ Birth Date _____ Age _____ Grade _____

Name of Parents/Guardian _____ Home# _____ Cell # _____ Text? Y/N
Address _____ Email _____

Child's Practitioner _____ Phone # _____

Please provide 2 emergency contacts:

Name _____	Phone # h- _____	cell# _____	Relationship _____
Name _____	Phone #h- _____	cell# _____	Relationship _____

Permission to provide necessary treatment or emergency care:

I hereby give permission to the medical personnel selected by Friends Academy staff to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event of an emergency, I hereby give permission to the physician selected by Friends Academy staff to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied and released to all medical personnel involved in my child's care.

signature of parent/guardian

date

Is your child allergic to anything? Please describe any allergic reactions your child has experienced:

Does an emergency medication need to be available at school? _____

Does your child have asthma? Yes ___ No ___ If yes, please describe specifically the type, severity, frequency and list all medications. _____

Does your child have any health conditions or limitations, past or present, of which we, as caregivers, should be aware? (For example: major diseases of the heart, lungs, intestines, kidneys, etc.; anemia; fainting; frequent respiratory or ear infections; broken bones; eating or stomach disorders; seizures; surgeries; behavior or learning disorders?) _____

Does your child take any medication, prescription or over-the-counter?

Yes ___ No ___ If yes, please

explain _____

SIDE 2 THIS SIDE TO BE FILLED OUT BY LICENSED PRACTITIONER – 2018-19

****Please note - Physician parents may not fill out this form for their own children.**

NAME: _____ DOB: _____ AGE: _____

General Appearance: _____ Ht: _____ Wt: _____ BMI: _____

B.P.: _____ Pulse: _____ *Vision Screen: _____ *Hearing Screen: _____

Please check "N" for normal or "A" for abnormal

	N	A	REMARKS
Skin			
Eyes, pupils, sclera, vision			
Ears, canals, drums, hearing			
Nose, septum, turbinates			
Mouth, tongue, lips, pharynx, tonsils			
Teeth, gums, last dental check up			
Neck, mobility, lymph nodes, thyroid			
Chest, lungs			
Heart: rate, rhythm, murmurs			
Abdomen, hernias, liver, spleen			
Ano-genital, penis, testicles, labia			
Musculo-skeletal, spine, extremities			
Neurological, cranial nerves			
ALLERGIES			

IMMUNIZATIONS: Record to be completed by a licensed professional

	DATE	DATE	DATE	DATE	DATE	DATE
Polio (IPV or OPV please specify)						
DPT/DTaP						
HIB						
Measles, Mumps, Rubella (MMR)						
Hepatitis B						
TD Booster						
*Lead screening required for preschool and new kindergartners						
Varicella (vaccine or disease?)						
Tuberculosis Screening Assessment						
Others (PCV, influenza, hep A)						

Is this child taking any medications?

Describe any behavior or learning disorders: _____

Any conditions requiring restrictions in school activities including PE and after school sports?

*Vision and Hearing Screenings are not done by Friends Academy

Date: _____ MD/NP/PA Signature _____

Please Attach Note Of "Religious Exemption," If Applicable.