MODEL SECONDARY SCHOOL FOR THE DEAF

Annual Physical Examination

Please bring this form to your physician (MD, DO, PA, or NP) to complete.

Name:			Sport(s):		
Sex:	Age:		Height:	Weight:	
BP: /			Pulse:	RR:	
Visual acuity: R 20/ L 20/			Color test		
OD	OS	Combined	w/ correction OD	w/ correction OS	Combined

CLINICAL EXAMINATION		
	NORMAL	**ABNORMAL FINDINGS**
Head, Face, Neck & Scalp		
Nose / Sinuses		
Mouth / Throat		
Ears (include hearing aid model, if applicable)		
Eyes		
Lung/Chest		
Heart/Cardiovascular		
Abdomen/GI		
Genitourinary System		
Skin/Lymphatics		
Neurological		
ORTHOPAEDIC EXAMINATION		
Cervical/Thoracic Spine		
Shoulder/Upper Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Lumbar Spine		
Hip/Thigh		
Knee		
Lower Leg		
Ankle/Foot		
Flexibility		

Impression:_____

- **Medical Clearance Status for Sports and/or Physical Activity**
  - □ Cleared without restrictions
  - □ Cleared with restrictions: _____
  - □ Not cleared / Further evaluation needed (use additional form):

    I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Examiner Print Name:_____Date:_____

Examiner's Signature:_____Physician's Office Name and Phone #:_____

Student Name: _____ **Date of Birth:** _____

VACCINATIONS

All new students must have a physical exam and tuberculin skin test or complete the Tuberculosis Assessment form within 12 months prior to being admitted to the **Model Secondary School for the Deaf**. Results must accompany completed Medical History and Annual Physical Exam forms.

	Date	Result	Date	Result	Date	Result
Tuberculin (Mantoux) PPD-5 TU						
Chest X-Ray (if PPD positive)						
Urine						
Other (including COVID-19)						

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

IMMUNIZATIONS – Immunizations must be verified by your healthcare provider. The student must have:
5 doses of Diphtheria/Tetanus/Pertussis (DTaP)
1 dose of TDap
4 doses of Polio
2 doses of Varicella or history of disease noting the month/year
2 doses of MMR
2 doses of Hepatitis A
3 doses of Hepatitis B
2 doses of Meningococcal (Men ACWY)
2 or 3 doses of Human Papillomavirus Vaccine (HPV) or complete HPV Opt-Out form

- 2 doses IF first dose of HPV received between 9 – 14 years of age with doses separated by 6 – 12 months. Three doses are required if HPV series is started on or after 15 years of age.

1 Influenza for upcoming flu season
COVID-19 vaccine(s) - required for ages 18 and older

	IMMUNIZATION HISTORY				
Diphtheria/Tetanus/Pertussis (DTaP/Td)					
TD/TDAP					
OPV (Polio Vaccine (Type:)					
IPV					
MMR (Measles, Mumps, Rubella)					
Varicella (or month & year child had chickenpox:)					
Hepatitis A					
Hepatitis B (Type:)					
Meningococcal Vaccine					
HPV (Human Papillomavirus)					
Influenza					
COVID-19 Vaccine					

_____
Date

_____
Printed name of provider

_____
Signature of provider

_____
Provider's Address

_____
Phone