

Bais Yaakov School for Girls
Middle School and High School
Record of Physical Examination

Dear Parents:

In order for your child to enter a new Bais Yaakov Division for the first time, the following requirements must be satisfied:

- A **physical examination** by a physician or certified nurse practitioner must be completed within nine months prior to entering the school or within six months after entering the school.
- Evidence of **complete primary immunizations** against certain childhood communicable diseases is required for all students. Immunizations required are determined by the Maryland Department of Health and Mental Hygiene and can be found under vaccine requirements for the current school year at <https://phpa.health.maryland.gov/OIDEOR/IMMUN/Pages/back-to-school-immunization-requirements.aspx>

Please note:

- Students may be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine and that exemption is then approved by the school's Immunization Board. All supporting documentation should be sent to the school nurse and identifying information will be removed for the Board to make a decision.
- The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.
- Part I must be completed by a parent or guardian.
- Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.
- If your child requires medication to be administered in school, you must have the physician complete and sign a medication administration form for each medication. This form must then be signed by a parent. This form can be obtained on our website www.baisyaakov.net or from <http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf>. If your child requires a special individualized health procedure, please contact the principal and/or school nurse.

PART I - HEALTH ASSESSMENT: To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care? Name:			Phone No.	
Address:				
When was the last time your child had a physical exam? Month		Year		
Where do you usually take your child for dental care? Name:			Phone No.	
Address:				
ASSESSMENT OF STUDENT HEALTH				
To the best of your knowledge has your child any problem with the following? Please check				
	Yes	No	Comments	
Allergies (Food, Insects, Drugs, Latex)				
Allergies (Seasonal)				
Asthma or Breathing Problems				
Behavior or Emotional Problems				
Birth Defects				
Bleeding Problems				
Cerebral Palsy				
Dental				
Diabetes				
Ear Problems or Deafness				
Eye or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication? No Yes Name(s) of Medications: _____				
Is your child on any special treatments? (nebulizer, epi-pen, etc.) No Yes Treatment _____				
Does your child require any special procedures? (catheterization, etc.) No Yes				
Parent/Guardian Signature _____			Date: _____	



PART II - SCHOOL HEALTH ASSESSMENT: To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
1. Does the child have a diagnosed medical condition? No Yes _____ _____ _____				
2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? _____ (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please work with your school nurse to develop an emergency plan. No Yes _____ _____				
3. Are there any abnormal findings on evaluation for concern? _____				
Evaluation Findings/CONCERNS				
Area of Physical Exam	WNL	ABNL	Concern	Health Area of Concern YES or NO
Head				Attention Deficit/Hyperactivity
Eyes				Behavior/Adjustment
ENT				Development
Dental				Hearing
Respiratory				Immunodeficiency
Cardiac				Lead Exposure/Elevated Lead
GI				Learning Disabilities/Problems
GU				Mobility
Musculoskeletal/orthopedic				Nutrition
Neurological				Physical Illness/Impairment
Skin				Psychosocial
Endocrine				Speech/Language
Psychosocial				Vision
				Other
REMARKS: (Please explain any abnormal findings.)				

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. No Yes _____ (A medication administration form must be completed for medication administration in school).		
6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction. No Yes _____		
7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		

PART II - SCHOOL HEALTH ASSESSMENT - continued

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has:

- no evident problem that may affect learning or full school participation including sports, exercise, and gym classes.
- problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date
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