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? Phone No.
Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.
Name: 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:

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

_____

Additional Comments:

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