THE HIGH SCHOOL SUMMER CONSERVATORY

Physical Examination Form (page 1 of 2)

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN OR NURSE PRACTITIONER.

1. STUDENT NAME: _____ _____
LAST NAME, FIRST NAME, MIDDLE INITIAL — DATE OF BIRTH (MONTH/DAY/YEAR)

2. VITAL SIGNS:

_____ _____ _____ _____ _____ _____
HEIGHT — WEIGHT — BLOOD PRESSURE — HR — T — R

3. ALLERGIES: ☐ NO KNOWN ALLERGIES

THIS STUDENT IS ALLERGIC TO: ☐ FOOD ☐ MEDICINE ☐ ENVIRONMENT ☐ OTHER (PLEASE SPECIFY BELOW)

PLEASE LIST WHAT THE STUDENT IS ALLERGIC TO AND ANY KNOWN REACTIONS, IF APPLICABLE:

4. DIET/NUTRITION

THIS STUDENT HAS: ☐ A REGULAR DIET ☐ MEDICALLY PERSCRIBED MEAL PLAN OR DIETARY RESTRICTION(S)

PLEASE LIST ANY DIETARY RESTRICTIONS OR PREFERENCES:

5. IMMUNIZATIONS

PLEASE LIST THE DATES THE STUDENT RECEIVED THE REQUIRED IMMUNIZATIONS:

MMR #1: _____ / #2: _____ MENINGOCOCCAL: _____ TDAP: _____

VARICELLA #1: _____ / #2: _____ OR ☐ HAD CHICKEN POX

6. PHYSICAL EXAMINATION

BODY SYSTEM	NORMAL	DESCRIBE ABNORMAL	MUSCULOSKELETAL	NORMAL	DESCRIBE ABNORMAL
APPEARANCE			NECK		
NEUROLOGIC			SHOULDERS/ ARMS/ ELBOW		
HEENY			WRIST/ HAND/ FINGERS		
DENTAL/MOUTH			HIPS		
LYMPHATIC			KNEES		
HEART			LEGS/ ANKLE		
LUNGS			FEET/ TOES		
ABDOMEN			POSTURAL/ SPINE		
GENITOURINARY			**MENTAL/LEARNING**	**NORMAL**	**DESCRIBE ABNORMAL**
SKIN			MENTAL/ EMOTIONAL LEARNING		

7. IS THE STUDENT CURRENTLY UNDERGOING TREATMENT FOR ANY CONDITION(S) OR HAS PAST MEDICAL HISTORY REQUIRING TREATMENT? ☐ YES ☐ NO *(IF YES, PLEASE DESCRIBE)*

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8. DOES THE STUDENT REQUIRE TREATMENTS/ THERAPIES TO BE PERFORMED DURING THE PROGRAM? ☐ YES ☐ NO ***(IF YES, PLEASE DESCRIBE)***

9. DO YOU FEEL THAT THE STUDENT WILL REQUIRE LIMITATIONS OR RESTRICTIONS TO ACTIVITY?
☐ YES ☐ NO ***(IF YES, PLEASE DESCRIBE)***

10. MEDICATION

☐ This student **WILL NOT** be taking any prescribed medications during the program
☐ This student will be taking the following prescribed medications during the program (please list medication(s) with the name, dose, frequency, purpose of medication):

11. EMERGENCY MEDICATION

Medications considered to be "Emergency Medications" may include but is not limited to: Epi-Pen, Rescue Inhaler, and Glucagon. Please list any "Emergency Medications" in the list above. In order for the student to self-administer emergency medication during this program, AMDA HSSC requires medical documentation from a health care provider stating the student is trained and capable of self-administration of these medications. All use of emergency medications will be monitored and recorded. Additionally, an emergency responder will be summoned if Epi-Pen/Epi-pen Jr is administered.

Health Care Provider: Please check below that pertains to the student and their emergency medication(s).
☐ This student **DOES NOT** require emergency medication.
☐ This student is trained to self-administer their emergency medication(s) and may carry their emergency medication(s) on their person to all program activities in their personal pack at all times

12. MEDICAL PERSONAL AUTHORIZATION

By signing this form, I have discussed the program with the student and their parent(s)/guardian(s). It is my opinion that the student, _____ *(check below that pertains to the student):*
PRINT STUDENT NAME

☐ Physically and emotionally fit to participate in AMDA HSSC's program activities.
☐ Physically and emotionally fit to participate in AMDA HSSC's program activities, ***with restrictions/limitations (as described above).***

Please email the completed & signed form to summerdocs@amda.edu

NAME OF LICENSED HEALTH CARE PROVIDER (PLEASE PRINT) _____ SIGNATURE & TITLE _____

OFFICE ADDRESS STREET _____ CITY _____ STATE/COUNTRY (IF OUTSIDE UNITED STATES) _____ ZIP/POSTAL CODE _____

TELEPHONE _____ DATE _____