NEW CONNECTIONS
PATHWAYS CAREER SERVICES
CREATING PATHWAYS TO NEW CONNECTIONS

Annual Physical Examination Form

HEALTH INFORMATION FORM

Individual's Full Name: _____
Individual's Date of Birth: _____ Sex: _____ Main Language Spoken: _____
Individual's Address: _____
City: _____ State: _____ Zip Code: _____
Name of Parent or Provider: _____
Phone Number: _____ Work or Cell: _____
Emergency Contact: _____ Phone: _____ Work or Cell: _____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavior problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problems			Seizures		
Bleeding problems			Sickle Cell Disease (not trait)		
Bowel problems			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information (for example: feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):

_____

_____

List all prescription, over-the-counter, and herbal medications taken regularly:

_____

_____

Please provide the following information:

	Name	Phone	Date of Last Appointment
Primary Care Provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I, _____ (do___)(do not____) authorize my health care provider and designated staff of PCS to discuss health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your PCS Administration.

Signature of Parent of Provider: _____ Date: _____

Signature of person completing this form: _____ Date: _____

COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete this section. The exam must be done yearly.

Individual's Name: _____ Date of Birth: _____ Sex: □M □F

Health Assessment

Date of Assessment: _____
Weight: ____lbs. Height: ____ft. ___in.
Body Mass Index (BMI): _____BP_____
□Age/gender appropriate history completed
□Anticipatory guidance provided

Physical Examination
1= within normal 2=Abnormal finding
3=Referred for evaluation or treatment

	1 2 3		1 2 3		1 2 3
HEENT	□ □ □	Neurological	□ □ □	Skin	□ □ □
Lungs	□ □ □	Abdomen	□ □ □	Genital	□ □ □
Heart	□ □ □	Extremities	□ □ □	Urinary	□ □ □

TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease □ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: □ Positive □ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ □ Normal □ Abnormal

Developmental Screen

Assessed for:	**Assessment Method:**	**Within Normal**	**Concern Identified:**	**Referred for Evaluation**
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

□ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box

	1000	2000	4000
R			
L			

□ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

□ Referred to Audiologist/ENT □**Unable to test – needs rescreen**

□Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

Vision Screen

□ With Corrective Lenses (check if yes)

Stereopsis □ Pass □ Fail				□ Not Tested
Distance	Both	R	L	Test Used:
	20/	20/	20/	

□ Pass □ Referred to eye doctor □ **Unable to test – Needs rescreen**

Dental Screen

□ Problem Identified: Referred for treatment
□ No Problem: Referred for prevention
□ No Referral: Already receiving dental care

Summary

Summary of Findings (check one):
□ **Well; no conditions identified of concern that could prohibit program activities**
□ Conditions identified that are important to physical activity (complete sections below and/or explain here):
_____
_____
____Allergy □food: _____ □ insect: _____ □ medicine _____ □ other: _____
Type of allergic reaction: □anaphylaxis □local reaction Response required: □none □epinephrine auto-injector □Other
____**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, sever allergy, etc.)
____**Restricted Activity** Specify: _____
____**Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____
____**Medication** □Medication must be given and/or available at center
____**Special Diet** Specify: _____
____**Special Needs** Specify: _____
Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) □ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ Signature: _____ Date: _____

Practice/Clinic Name: _____ Address: _____
Phone: _____ Fax: _____ Email: _____