

CHILD AND YOUTH HEALTH ASSESSMENT/SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations of restriction on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

NAME OF SPONSOR	RANK	TELEPHONE (HOME)	TELEPHONE (WORK)
SPONSOR UNIT ADDRESS	SPONSOR SSN	SPOUSE'S WORK PHONE	

CHILD HEALTH INFORMATION

NAME OF CHILD	BIRTH DATE	SEX
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HAS YOUR CHILD BEEN UNDER THE SUPERVISION OF A PHYSICIAN? (IF YES, PLEASE EXPLAIN CIRCUMSTANCES AND CURRENT STATUS)

IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM NO / YES LAST UPDATE:

IMMUNIZATIONS

	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						TD
HIB						PPD
POLIO						
HEP B				INFLUENZA		
MMR			HEP A			
VARICELLA			OTHER			

MEDICAL HISTORY

	YES	NO		YES	NO
1. ANY HOSPITALIZATION OR OPERATIONS			15. BROKEN BONES OR SPRAINS		
2. ALLERGIES TO MEDICINE OR INSECT BITES			16. JOINT INJURIES (ANKLE / KNEE / WRIST)		
3. SPEECH OR DEVELOPMENTAL DELAYS			17. REQUIRED RESTRICTED PHYSICAL ACTIVITY		
4. VISION PROBLEMS (GLASSES/CONTACTS)			18. FAMILY HISTORY OF DEATH LESS THAN AGE 40		
5. EAR OR HEARING PROBLEMS			19. FAMILY HX OF HEART DISEASE/STROKE < AGE 55		
6. SEIZURES OR CONVULSIONS			20. DIABETES		
7. DIZZINESS OR FAINTING WITH EXERCISE			21. LEUKEMIA		
8. HEADACHES			22. DENTAL OR ORTHODONTIC BRACES		
9. HEAD INJURY OR LOSS OF CONSCIOUSNESS			23. CHICKEN POX		
10. NECK OR BACK INJURY			24. CHILDHOOD ILLNESS: (MUMPS, RUBELLA, MEASLES)		
11. ASTHMA OR DIFFICULTY BREATHING			25. SLEEP PROBLEMS		
12. HEART OR BLOOD PRESSURE PROBLEMS			26. RHEUMATIC FEVER		
13. CHEST PAIN WITH EXERCISE			27. ROUTINE OR DAILY MEDICATIONS (LIST BELOW)		
14. HEAT STROKE OR EXHAUSTION			28. OTHER PROBLEMS (LIST BELOW)		

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

I GIVE PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE:		YES	NO
1. RECEIVE A PPD SKIN TEST FOR TUBERCULOSIS			
2. RECEIVE ANY IMMUNIZATION(S) NECESSARY			
3. RECEIVE A HEALTH SCREEN EXAMINATION FOR SPORTS/SCHOOL/SCOUTS/CYS/OTHER			
4. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CYS			

TYPED OR PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN
RE-CERTIFICATION: SIGNATURE OF PARENT OR GUARDIAN	DATE:

MEDICAL STAFF ASSESSMENT (FILLED OUT BY LICENSED HEALTH CARE PROFESSIONAL)

AGE:	YRS	MOS	HEIGHT:	cm(%ile)	WEIGHT:	kgs.(%ile)	BP	/	P
			HEIGHT:	in	WEIGHT:	lbs.			
VISUAL ACUITY:		RIGHT	LEFT	tested with/without lenses		NORMAL	ABNORMAL		
			NORMAL	ABNORMAL	N/A	COMMENTS			
1.	EYES								
2.	EARS, NOSE & THROAT								
3.	HEARING								
4.	MOUTH AND TEETH								
5.	NECK (SOFT TISSUE)								
6.	CARDIOVASCULAR								
7.	CHEST AND LUNGS								
8.	ABDOMEN								
9.	GENITALIA - HERNIA								
10.	SKIN AND LYMPHATICS								
11.	NECK								
12.	SPINE - SCOLIOSIS								
13.	EXTREMITIES								
14.	NEUROLOGICAL								
15.	WEARS GLASSES/CONTACTS								
16.	WEARS DENTAL BRIDGES								
17.	WEARS BRACES/PLATES								

BASED ON THIS HX AND PX EXAM, THE FOLLOWING ABNORMALITIES WERE FOUND AND MAY NEED TREATMENT:

ON-GOING MEDICATION

TYPE	DOSAGE	FREQUENCY	TYPE	REACTION

ALLERGIES

PARTICIPATION RECOMMENDATIONS

- | | |
|--|---|
| <input type="checkbox"/> NORMAL PHYSICAL ACTIVITIES INCLUDING PE | <input type="checkbox"/> CONTACT SPORTS |
| <input type="checkbox"/> CHILD AND YOUTH SERVICES | <input type="checkbox"/> NON-CONTACT SPORTS |
| <input type="checkbox"/> COLLISION SPORTS | <input type="checkbox"/> HIGH RISK |

THIS STUDENT HAS A HEALTH PROBLEM WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS:

- NO
 YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

SPORTS PHYSICAL IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW

DATE	LICENSED HEALTH CARE PROFESSIONAL STAMP	LICENSED HEALTH CARE PROFESSIONAL SIGNATURE
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