



January 23, 2023

Dear Parents/Legal Guardians:

We are pleased to offer your 8<sup>th</sup> grade students the opportunity to get their required 9<sup>th</sup> grade physical completed at school this year. For your convenience we are offering the opportunity to have these physical completed at your school.

Attached to this letter you will find the physical form and required consent form to allow your student to receive their physical exam by one of our CMH Practitioners on Tuesday April 18, 2023 at Nuttall Middle School.

- Answer the questions and sign the "health history" portion of the physical form.
- Complete the clinic patient registration form and bring a copy of your insurance card with you. We accept Medicaid and most Insurances. Be sure to include the name of the Insurance Company and the ID and/or policy number. If you have any questions regarding your insurance or if your child doesn't have insurance, please give us a call at 618-544-5517.

Return all listed paperwork above, along with this letter marking which day you would like to advantage of these services. Send this information with your child to your school by Monday April 3, 2023 to take advantage of these services.

Sincerely,

Crawford Memorial Hospital  
Rural Health Clinics

Last			First			Middle			Birth Date			Sex	School			Grade Level/ ID		
Last			First			Middle			Month/Day/ Year									
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																		
<b>ALLERGIES</b> (Food, drug, insect, other)			Yes	No	List:			<b>MEDICATION</b> (Prescribed or taken on a regular basis.)			Yes	No	List:					
Diagnosis of asthma?			Yes	No				Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes	No						
Child wakes during night coughing?			Yes	No				Hospitalizations? When? What for?			Yes	No						
Birth defects?			Yes	No				Surgery? (List all) When? What for?			Yes	No						
Developmental delay?			Yes	No				Serious injury or illness?			Yes	No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No				TB skin test positive (past/present)?			Yes*	No	*If yes, refer to local health department.					
Diabetes?			Yes	No				TB disease (past or present)?			Yes*	No						
Head injury/Concussion/Passed out?			Yes	No				Tobacco use (type, frequency)?			Yes	No						
Seizures? What are they like?			Yes	No				Alcohol/Drug use?			Yes	No						
Heart problem/Shortness of breath?			Yes	No				Family history of sudden death before age 50? (Cause?)			Yes	No						
Heart murmur/High blood pressure?			Yes	No				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other										
Dizziness or chest pain with exercise?			Yes	No				Information may be shared with appropriate personnel for health and educational purposes.										
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)								<b>Parent/Guardian Signature</b>									<b>Date</b>	
Ear/Hearing problems?			Yes	No														
Bone/Joint problem/injury/scoliosis?			Yes	No														
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																		
HEAD CIRCUMFERENCE if < 2-3 years old			HEIGHT			WEIGHT			BMI			BMI PERCENTILE			B/P			
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>																		
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____																		
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____																		
<b>LAB TESTS (Recommended)</b>			Date			Results			Date			Results						
Hemoglobin or Hematocrit						Sickle Cell (when indicated)												
Urinalysis						Developmental Screening Tool												
<b>SYSTEM REVIEW</b>		Normal	Comments/Follow-up/Needs					Normal		Comments/Follow-up/Needs								
Skin								Endocrine										
Ears			Screening Result:					Gastrointestinal										
Eyes			Screening Result:					Genito-Urinary		LMP								
Nose								Neurological										
Throat								Musculoskeletal										
Mouth/Dental								Spinal Exam										
Cardiovascular/HTN								Nutritional status										
Respiratory			<input type="checkbox"/> Diagnosis of Asthma					Mental Health										
Currently Prescribed Asthma Medication:								Other										
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																		
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																		
<b>NEEDS/MODIFICATIONS</b> required in the school setting							<b>DIETARY</b> Needs/Restrictions											
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																		
<b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal																		
<b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.																		
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)																		
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>															
Print Name						(MD,DO, APN, PA) Signature						Date						
Address												Phone						

# New Patient Clinic Registration Form

<b>Patient's Name:</b>		<b>Patient's Birthdate:</b>	<b>Patient's Sex:</b>
<b>Former/Previous Name/Nickname:</b>		<b>Email:</b>	
<b>Home Phone #:</b>	<b>Cell Phone #:</b>	<b>Social Security Number:</b>	<b>Marital Status:</b>
<b>Mailing Address:</b>			
<b>Preferred Language:</b>	<b>Ethnicity &amp; Race (Check one):</b> <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/> Native American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black		
<b>Employment Status:</b> <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Full-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired: Date _____ <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student Full-Time <input type="checkbox"/> Student Part-Time <input type="checkbox"/> Disabled: Date _____			
<b>Employer Name, Address, and Phone Number:</b>			
<b>Preferred Pharmacy:</b>		<b>Mail Order Pharmacy:</b>	
<b>Primary Care Provider:</b>			

## Parent/Guardian Information if Under 18 years of age/Person consenting to treatment

<b>Parent/Guardian Name:</b>	
<b>Relationship to Patient:</b>	<b>Parent/Guardian Date of Birth:</b>
<b>Address and Phone Number(if different from Patient):</b>	

## Insurance Information –Please provide insurance card(s) to the receptionist

<b>Primary Insurance:</b>	<b>Policy Holder's Name:</b>
<b>Policy Holder's Date of Birth:</b>	<b>Relationship to Patient:</b>
<b>Policy ID Number:</b>	<b>Policy Holder's Employer:</b>
<b>Policy Holder's Address (if Different from Patient):</b>	
<b>Secondary Insurance:</b>	<b>Policy Holder's Name:</b>
<b>Policy Holder's Date of Birth:</b>	<b>Relationship to Patient:</b>
<b>Policy ID Number:</b>	<b>Policy Holder's Employer:</b>
<b>Policy Holder's Address (if Different from Patient):</b>	
<b>Tertiary Insurance:</b>	<b>Policy Holder's Name:</b>
<b>Policy Holder's Date of Birth:</b>	<b>Relationship to Patient:</b>
<b>Policy ID Number:</b>	<b>Policy Holder's Employer:</b>
<b>Policy Holder's Address (if Different from Patient):</b>	



Crawford Memorial Hospital Rural Health Clinic must receive permission from a child's parent or legal guardian prior to providing treatment. This form provides the legal permission for this child,

\_\_\_\_\_, date of birth \_\_\_\_\_

to receive a school physical at Nuttall Middle School without my physical presence on Tuesday April 18, 2023. I have completed the parental section of the physical form that will be completed by the practitioner at the time of service. A copy of school physical form will be provided to the school and a copy should be mailed to my attention at

\_\_\_\_\_  
\_\_\_\_\_.

Printed Parent/Guardian Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_