WASHINGTON STATE SCHOOL FOR THE BLIND MEDICAL EVALUATION FOR SCHOOL ATTENDANCE AND SCHOOL SPORTS

This section is to be completed by parent/guardian, reviewed by student's medical provider during exam and returned to WSSB nurses

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your student 'sports activity for any reason?		
2. Does your student have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Has your student ever spent the night in the hospital?		
4. Has your student ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOUR STUDENT	**Yes**	**No**
5. Has your student ever passed out or nearly passed out DURING or AFTER exercise?		
6. Has your student ever had discomfort, pain, tightness, or pressure in the chest during exercise?		
7. Does your students heart ever race or skip beats during exercise?		
8. Has a doctor ever told your student that they have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your student's heart? (For example, ECG/EKG, echocardiogram)		
10. History of feeling lightheaded or more short of breath than expected during exercise?		
11. Has your student ever had an unexplained seizure?		
12. History of being tmore tired or short of breath compared to friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR STUDENTS FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your student's family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your student's family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your student's family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. History of injury to bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Has your student ever had any broken or fractured bones or dislocations		
19. Has your student ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Has your student ever had a stress fracture?		
21. Has your student ever been told they have neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Does your student regularly use a brace, orthotics, or other device?		
23. Does your student have a bone, muscle, or joint injury?		
24 History of swollen or painful joints?		
25. Any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Does your student cough, wheeze, or have difficulty breathing during or after exercise?		
27. Has your student ever used an inhaler or taken asthma medicine?		
28. Is there anyone in the family who has asthma?		
29. History of missing a kidney, eye, a testicle (males), spleen, or any other organ?		
30. Does your student have groin pain, painful bulge, hernia in the groin		
31. History of infectious mononucleosis (mono) within the last month?		
32. History of rashes, pressure sores, or other skin problems?		
33. History of herpes or MRSA skin infection?		
34. History of a head injury or concussion?		
35. History of a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Does your student have a history of seizure disorder?		
37. Does your student have headaches with exercise?		
38. History of, tingling, weakness in your arms or legs after being hit or falling?		
39. Has your student ever been unable to move your arms or legs after being hit or falling?		
40. History of becoming ill while exercising in the heat?		
41. History of frequent muscle cramps when exercising?		
42. Family history of sickle cell trait or disease?		
43. Any problems with your eyes or vision?		
44. History of any eye injuries?		
45. Does your student wear glasses or contact lenses?		
46. Use of protective eyewear, such as goggles or a face shield?		
47. Does your student worry about their weight?		
48. Has student been advised to gain or lose weight?		
49. Any special diet or do avoidance of certain types of foods?		
50. History of eating disorder?		
51. Any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Has your student ever had a menstrual period?		
53. Age at first menstrual period?		
54. How many periods in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Guardian Signature: _____ Date: _____

WASHINGTON STATE SCHOOL FOR THE BLIND MEDICAL EVALUATION FOR SCHOOL ATTENDANCE AND SCHOOL SPORTS

This section completed by student's medical provider and returned to WSSB nurses

Name _____

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmers • PMI		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

Please list medical diagnoses	_____ _____
Does the student have a seizure disorder? Yes / No	*If yes, please attach a seizure action plan to be used at school*
If applicable, please describe seizure activity.	List type of seizure disorder (grand mal, petite mal, etc.) _____
Does the student have a shunt? Yes / No	*If yes, what kind*:_____ Left Right
Has the student been diagnosed with an endocrine disorder? Yes / No	*If yes, please attach a plan to be used at school*
Has the student been diagnosed with asthma? Yes / No	*If yes, please attach an asthma action plan to be used at school*
Does the student have any food, medication or environmental allergies? Yes / No	*If yes, please list all known allergies*: _____

WASHINGTON STATE SCHOOL FOR THE BLIND MEDICAL EVALUATION FOR SCHOOL ATTENDANCE AND SCHOOL SPORTS

Does the student have any dietary restrictions or special diets? Yes/No	Please describe how ingestion or contact with the food impacts the student_____ What specific foods need to be omitted from the students diet_____ List food and beverages to be substituted, provided or modifies_____
Does the student have any activity restrictions? Yes / No	*If yes, please describe*: _____ How long will this activity restriction be necessary? _____
Does the student have, or at risk of retinal detachment? Yes / No	If yes, please describe: _____
Will student take prescribed medication while at WSSB?	If yes, please complete section below.

Name of Medication	Dosage	Time to be given and Method of administration	Reason for medication and Side Effects to Watch For

Please Note: Medication MUST be provided to WSSB nurses in original containers per RCW 28A.210.260(6)

Provider, please cross out OTC medications/preparations student may NOT have while at WSSB:

ORAL: Tylenol Advil Aleve Benadryl Loratadine Cetirizine Robitussin DM Guaifenesin Phenylephrine Cough Drops Tums Mylanta Docusate Sodium Miralax Melatonin

TOPICAL: Burn Gel Vaseline Sting-relief w/ lidocaine Chapstick Cold Sore Treatment Tolnaftate Alcohol Wipes Hydrocortisone Cream Antibiotic Ointment Sunscreen Aloe Vera Gel Vicks Vapo-Rub

Provider, please note: WSSB offers a variety of activities and sports not traditionally found in public school, please carefully read activity and sports listed below and consider students medical risks, such as VP shunt, seizure disorder, retinal detachment risk, etc. All school sponsored sports and activities are supervised, and consideration is made for the student's vision impairment Please cross out activities or sports student may not participate in.

Activities offered: downhill skiing, cross-country skiing, snow-mobiling, trampoline park, horseback riding, tandem cycling, yoga, paddle boarding, martial arts, hiking, track meet, basket-ball, archery, swimming

Sports offered: power-lifting, goal ball

Cleared for all sports and activities Yes/No _____except: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to the practice in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made to the school at the request of parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student/athlete (and parents/guardians.)

Name of Medical Provider (print/type)_____ Date_____

Address_____ Phone_____

Signature of Medical Provider_____