Washington State School for the Blind
2214 E. 13th St. · Vancouver, Washington 98661-4120
(360) 696-6321 · FAX # (360) 737-2120

Medical Evaluation For School Attendance And School Sports Form

This form is good for 2 years and must be renewed every two years. Required for students taking routine medication(s), if a student has a life threatening health condition or participating in school sports

Student Name _____ Gender assigned at birth _____ Gender identity _____

Examination

Height _____ Weight _____ BP _____ Pulse _____

Vision R 20/ _____ L 20/ _____

Corrected ☐ Yes ☐ No

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] • Murmurs • PMI	☐	
Pulses • Simultaneous femoral and radial pulses	☐	
Lungs	☐	
Abdomen	☐	
Genitourinary (males only)[b]	☐	
Skin • HSV, lesions suggestive of MRSA, tinea corporis	☐	
Neurologic [c]	☐	

Musculoskeletal

	Normal	Abnormal Findings
Neck	☐	
Back	☐	
Shoulder/arm	☐	
Elbow/forearm	☐	
Wrist/hand/fingers	☐	
Hip/thigh	☐	
Knee	☐	
Leg/ankle	☐	
Foot/toes	☐	
Functional • Duck-walk, single leg hop	☐	

Diagnoses

Please list medical diagnoses

Does the student have a seizure disorder?

☐ Yes ☐ No

If yes, please attach seizure action plan to be used at school

If applicable, please describe seizure activity and list type of seizure disorder (grand mal, petite mal, etc.)

Does the student have a shunt?

☐ Yes ☐ No

If yes, what kind?

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 known allergies

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 modified.

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 is at risk of retinal detachment?

☐ Yes ☐ No

If yes, please describe

Medications

Will student take prescribed medication while at WSSB?

☐ Yes ☐ No

If yes, please complete table 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	Cetirizine	Tums
Advil	Robitussin DM	Mylanta
Aleve	Guaifenesin	Docusate Sodium
Benadryl	Phenylephrine	MiraLAX
Loratadine	Cough Drops	Melatonin

Topical

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

Activities

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 blindness/low vision

Please cross out activities or sports student may not participate in.

Activities offered:

downhill skiing	tandem cycling	track meet
cross-country skiing	yoga	basketball
snowmobiling	paddle boarding	archery
trampoline park	martial arts	swimming
horseback riding	hiking	

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 pre-participation 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

*This form is valid for 2 years from the date signed by the medical provider above