CRAWFORD
MEMORIAL HOSPITAL

January 23, 2023

Dear Parents/Legal Guardians:

We are pleased to offer your 5th grade students the opportunity to get their required 6th 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 Lincoln Grade 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 (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	**MEDICATION** (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				
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	Yes No		**Parent/Guardian Signature**		**Date**

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: 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.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____
Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**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		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER 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: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION 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 ☐ **No** ☐ 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.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

New Patient Clinic Registration Form

Patient's Name:		**Patient's Birthdate:**	**Patient's Sex:**
Former/Previous Name/Nickname:		Email:	
Home Phone #:	**Cell Phone #:**	**Social Security Number:**	**Marital Status:**
Mailing Address:			
Preferred Language:	**Ethnicity & Race (Check one):** __White/Caucasian __Hispanic/Latino __Other __Native American __American Indian __Asian __African American/Black		
Employment Status: ☐ Active Military Duty ☐ Full-Time ☐ Not Employed ☐ Part-Time ☐ Retired: Date_____ ☐ Self-Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Disabled: Date _____			
Employer Name, Address, and Phone Number:			
Preferred Pharmacy:		**Mail Order Pharmacy:**	
Primary Care Provider:			

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

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

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

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

CRAWFORD
MEMORIAL HOSPITAL

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 Lincoln Grade 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: _____