



STATE OF TENNESSEE
ATTN: CLINIC
Tennessee School for the Blind

And

Educational Resource Center for the Visually Impaired

115 Stewarts Ferry Pike – Nashville, Tennessee 37214

CLINIC PHONE: 615-231-7399 or CLINIC FAX: 615 231-7417

MARCH 11, 2010

DEAR PARENTS AND GUARDIANS:

ENCLOSED YOU WILL FIND A COPY OF THE PHYSICAL FOR 2010-2011.

**A PHYSICIAN MUST SIGN THE PHYSICAL EXAM FORM.
PARENTS MAY FILL OUT THE STUDENT HISTORY FORM.**

THIS PHYSICAL IS REQUIRED FOR CAMP, SPORTS, AND SCHOOL (Many of our students receive medication at school and we need a doctor's order for all medication students receive in the clinic, and current medical conditions. TN. Care pays for a yearly physical).

THIS PHYSICAL MAY BE USED FOR CAMP, SPORTS ACTIVITY AND SCHOOL REGISTRATION.

IF A STUDENT COMES TO CAMP, AND ATTENDS SCHOOL IN THE FALL, WE WILL KEEP A COPY OF THIS PHYSICAL FOR REGISTRATION.

WHEN YOUR PHYSICIAN COMPLETES PHYSICAL, PLEASE SEND A COPY TO SCHOOL, AND KEEP A COPY OF THE PHYSICAL FOR YOUR FILE.

Sincerely,

**PAMELA FITTS, RN IV
CLINIC SUPERVISOR**

TSB PHYSICAL FOR 2010-2011

PHYSICIAN MUST SIGN PHYSICAL 2 PAGES / PHYSICAL WITH HISTORY (parent may fill out history form)

STUDENTS NAME: _____ SEX _____ DATE OF BIRTH: _____
 STUDENT'S SS. # _____ NAME OF PARENT OR GUARDIAN; _____
 PHONE NUMBER OF PARENT: _____

PHYSICAL FINDINGS:

ALLERGIES: _____
 HT. _____ WT. _____ BODY MASS INDEX: _____
 BP: _____ RESPIRATIONS: _____ PULSE: _____ TEMP. _____

PLEASE CHECK THE FOLLOWING:

PHYSICAL EXAM	NORMAL	ABNORMAL
EAR, EYE, NOSE, THROAT		
HEARING		
HEART		
CHEST AND LUNGS		
SKIN, LYMPHATIC		
GENITALIA		
ABDOMEN		
NECK, BACK, SPINE (SCOLIOSIS?)		
SHOULDERS AND ARMS		
ELBOWS AND FOREARMS		
WRISTS HANDS AND FINGERS		
HIP AND THIGHS		
KNEES, LEGS, AND ANKLES		
FEET AND TOES		

IMMUNIZATIONS CURRENT: _____ LAST TETANUS: _____
 CURRENT DIET ORDERS: _____

THIS STUDENT MAY PARTICIPATE IN SPORTS/OR OTHER PHYSICAL ACTIVITIES WITHOUT RESTRICTIONS _____

IF RESTRICTIONS PLEASE LIST: _____
 (SPORTS INCLUDE: SWIMMING, CONTACT SPORTS SUCH AS WRESTLING AND GO-BALL, TRACK, CHEERLEADING, ETC.)

TSB PHYSICAL FOR 2010-2011

THIS STUDENT MAY NOT PARTICIPATE IN SPORTS/ PHYSICAL ACTIVITIES _____

STUDENT NAME: _____

PRIOR TO PHYSICAL ACTIVITY OR SPORTS ACTIVITY, THE FOLLOWING IS RECOMMENDED:

MEDICAL DIAGNOSIS PLEASE

LIST: _____

LIST ALL CURRENT MEDICATIONS PRESCRIBED;

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

MED: _____ DOSAGE, TIME, ROUTE: _____

PHYSICIAN'S NAME

(PRINT): _____

PHYSICIAN'S SIGNATURE:

ADDRESS:

PHONE: _____ DATE: _____

ADDITIONAL PHYSICIAN

COMMENTS: _____

TSB PHYSICAL FOR 2010-2011

TENNESSEE SCHOOL FOR THE BLIND STUDENT HISTORY

STUDENT'S NAME: _____ DATE OF BIRTH _____

ALLERGIES: _____

CHECK ALL THAT APPLY BELOW:

ACTIVITY RESTRICTIONS		EYE DISEASE		PARALYSIS	
ADHD					
		FREQUENT FAINTING		PAIN IN CHEST UPON EXERTION	
ACID RELUX		FREQUENT HEADACHES		PNEUMONIA	
ANGER MANAGEMENT PROBLEM				POST TRAUMATIC STRESS	
APPENDICITIS		GASTRIC REFLUX		PRECOCIOUS PUBERTY	
ALLERGIC REACTION		GLASSES OR OPTICAL DEVICE		ORGAN TRANSPLANT	
AUTISM		GALL BLADDER PROBLEMS		RESPIRATORY PROBLEMS	
ARTIFICIAL APPLIANCE/AFO		GLAUCOMA		RETINAL DETACHMENT	
ASTHMA		GROWTH ABNORMALITIES		RHEUMATIC DISTRESS	
BEHAVIORAL PROBLEMS		HEAD OR NECK INJURY		RUBELLA	
BLOOD DISORDER		HEARING DEFICIT		SEIZURE DISORDER	
BROKEN BONE/BONES		HERPES		SEPTO OPTIC DISPLASIS	
BLINDNESS		HEART PROBLEMS		SICKLE CELL ANEMIA	
BRONCHITIS		HEART MURMUR		SKIN DISEASE	
BREATHING PROBLEMS		HEAT STROKES		SHUNT	
CANCER		HEMMORHOIDS		SLEEPING PROBLEMS	
CAR OR AIR SICKNESS		HEPATITIS		STOMACH PROBLEMS	
CEREBRAL PALSY				STREP THROAT	
CHEST PAIN		HERNIA		THYROID DISEASE	
CHRONIC COUGH		HERPES INFECTION		TRAUMA	
CHICKEN POX		HIGH BLOOD PRESSURE		TOBACCO USE	
CHOKING (DIFFICULTY SWALLOWING)		HIGH CHOLESTEROL		TUBERCULOSIS	
CONCUSSION		HYPOGLYCEMIA		TUMOR	
CYST		INCONTINENT TO URINE OR FECES		ULCER	
DEAFNESS		IRREGULAR HEART BEATS			
DEPRESSION		KIDNEY DISEASE			
DIABETES MELLITUS		LIVER DISEASE		PLEASE LIST BELOW: OTHER DISEASES OR EYE PROBLEMS	
DIABETES INSIPIDUS		MALARIA			
DEPRESSION		MEASLES			
DRUG ABUSE		MENINGITIS			
EAR PROBLEMS OR TUBES		MULTIPLE SCHLEROIS			
EATING DISORDER		MENSTRUAL PROBLEMS			
ENDOCRINE DISEASE		MIGRAINE HEADACHES			
ENCEPHALITIS		MUMPS			
		MENTAL DIAGNOSIS			

LIST SURGERIES _____

PARENTS/GUARDIAN'S SIGNATURE _____ **DATE** _____

OVER- THE-COUNTER PERMISSION

The following over-the-counter medications will be available in the TSB clinic to treat minor illness and injury:

1. Acetaminophen/Tylenol

Used for relief of fever, minor aches and pains.

Available in liquid and tablets.

Dosage according to package directions.

2. Ibuprofen/Motrin

Used for relief of fever, minor aches and pains.

Available in liquid and tablets.

Dosage according to package directions.

3. Benadryl

Used for perennial and seasonal allergic rhinitis, allergic conjunctivitis due to inhalant allergens and foods; mild uncomplicated allergic skin manifestations of urticaria, active and prophylactic treatment of motion sickness and insect stings.

Available in liquid and capsules.

Dosage according to package directions.

4. Maalox

Used for indigestion, relief of minor stomach aches.

Available in liquid.

Dosage according to package directions.

5. Triple Antibiotic Ointment

Used to treat minor cuts and abrasions.

Apply locally as needed according to package directions.

6. Hydrocortisone Cream

Used for relief of itching and rashes.

Apply locally as needed according to package directions.

7. Unguentine Burn Cream

Used for relief and healing of minor burns or sunburn

Apply locally as needed according to package directions.

8. Lamisil/Mycolog II Cream

Used to treat athlete's foot, jock itch and ringworm

Apply locally as needed according to package directions.

9. Orajel

Used for minor toothache until dentist can be consulted. .

Apply small amount to tooth and gum according to package directions.

I agree for my child to receive over-the-counter medication for minor illness and injury. I understand that it is my responsibility to supply the TSB clinic with any other medication that my child may require.

Student Name _____

Parent/Guardian Signature _____ Date _____

**AUTHORIZATION TO ASSIST COMPETENT STUDENT
WITH SELF-ADMINISTRATION- OF MEDICATION**

Student's Name: _____

I request that Tennessee School for the Blind personnel assist my child, whose name appears above, to self-administer any and all medication(s) that has been prescribed for- him/her.

I understand that my son/daughter will self-administer medication with assistance from school staff in accordance with TCA 49-5-415 and I declare that he/she is competent to do so.

Parent/Guardian Signature

Date

Parent/Guardian Name (please Print)

Home Phone Number

Emergency Phone Number

Work Phone Number

Other Phone Number

Comments:

THE SCHOOL SHALL RETAIN THIS FORM ON FILE FOR THREE YEARS