# PHYSICAL EXAMINATION

**BY LICENSED PROVIDER**

**PARENTS: PLEASE KEEP A COMPLETED COPY OF THIS FORM**

Motion41 Dance requires that all boarding program participants provide documentation of a physical examination within twelve (12) months preceding their initial arrival at the school. This form is to be completed by a Licensed Care Provider. Both pages must be completed. We ask that the licensed care provider advise us of any health concerns, allergies, dietary or activity restrictions. Please be specific and use the space provided or the reverse side is more space is needed.
NOTE: The student has been accepted to the Summer program. Information supplied will not affect acceptance status and will be used for providing health care. This information is strictly for the use of the school and will not be released without consent.

**I have examined _____ on _____**

Patient's Name Date of Exam

**IMMUNIZATION HISTORY:** Please record the dates (month/year) of basic immunizations and most recent booster:

| **VACCINE** | **DATES** | | | | | |
|---|---|---|---|---|---|---|
| DPT | | | | | | |
| Td | | | | | | |
| OPV/IPV | | | | | | |
| MMR | | | | | | |
| Hib | | | | | | |
| Hepatitus B | | | | | | |
| PPD/Mantoux | | | | | | |
| Varicella | | | | | | |
| Meningitis | | | | | | |
| Other(s) | | | | | | |

**PHYSICAL EXAMINATION:**

| HEIGHT | WEIGHT | BMI | PULSE | RESPIRATIONS | BP |
|---|---|---|---|---|---|
| | | | | | |

| **SYSTEM** | **NORMAL** | **COMMENTS AND/OR CONCERNS** |
|---|---|---|
| General Appearance | | |
| Skin | | |
| Eyes/Vision | | |
| Ears/Hearing | | |
| Nose | | |
| Mouth/Teeth | | |
| Cardiovascular | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary | | |
| Musculoeskeletal | | |
| Neurologic | | |
| Development | | |
| Other | | |

**PHYSICAL EXAMINATION BY A LICENSED PROVIDER: PAGE 2**

Student's Name: _____

**ALLERGY HISTORY:**

Does the patient have any allergies? Yes ___ No ____

Does the patient carry an EpiPen? Yes ___ No ____

**Note: Patient will need to come to the program with TWO EpiPens*

PLEASE DESCRIBE THE ALLERGEN, TYPICAL RESPONSE AND TREATMENT PLAN.

| Allergen | Typical Reaction | Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Additional information for the school to be aware of (dietary restrictions, activity restrictions, etc.):

**Please list any medications taken by the patient on a daily or regular basis (prescription and/or over-the-counter):**

_____

_____

**Complete a "Prescription Medication Form" for EACH prescription medication.**

VALIDATION OF EXAMINATION: In my opinion, the above individual may participate in an intensive arts program with noted restriction.

Name of licensed M.D. completing the Physical Examination: _____

Date of Exam: _____ Address: _____ City: _____

Phone: _____ Fax: _____

Licensed M.D. Signature: _____ Date: _____