HPA
Hawai'i Preparatory Academy

2021-2022 Physical Examination Form

DUE DATE: AUGUST 1, 2021

Please print and ask a US licensed health care provider to complete in full.
This form will need to be uploaded to Magnus Health by August 1.

Fill out this entire required Physical Examination Form. *HPA may delay class entry to a student **who has not** met all the health requirements by the first day of school. All **NEW STUDENTS** entering HPA are required to have a CURRENT physical exam completed by US licensed health care provider. If your child is a returning student and entering grades 7 and 9 through 12, or postgraduate year, and NOT new to HPA, this physical exam form may be completed by your local health care provider.*

Student name: _____ Date of birth: _____ Grade: _____

HEALTH HISTORY - This section is to be completed by a parent/guardian.

ILLNESSES - Mark Yes or No and indicate date of occurrence(s).

Y/N		Date	Y/N		Date	Y/N		Date
☐☐	Chicken Pox:	_____	☐☐	Depression:	_____	☐☐	High Blood Pressure:	_____
☐☐	Measles:	_____		Rx:	_____	☐☐	Hepatitis:	_____
☐☐	Mumps:	_____	☐☐	Bi Polar:	_____	☐☐	Liver Disease:	_____
☐☐	Rubella:	_____		Rx:	_____	☐☐	Kawasaki Disease:	_____
☐☐	Poliomyelitis:	_____	☐☐	Mononucleosis:	_____	☐☐	Diabetes:	_____
☐☐	Diphtheria:	_____	☐☐	Asthma:	_____		Most Recent HbgAIC:	_____
☐☐	Whooping Cough:	_____	☐☐	Eczema:	_____	☐☐	Anemia:	_____
☐☐	Rheumatic Fever:	_____	☐☐	Acne:	_____	☐☐	Eating Disorder:	_____
☐☐	Typhoid Fever:	_____	☐☐	Heart Condition:	_____	☐☐	STD:	_____
☐☐	Epilepsy/Seizures:	_____	☐☐	Heart Murmur:	_____	☐☐	Sleep Disorder/Apnea:	_____
☐☐	COVID-19 (SARS-CoV-2):	_____						

INJURIES - Check Yes or No and indicate date of occurrence(s) and location of injury(ies).

Y/N		Date	Y/N		Date
☐☐	Injuries:	_____	☐☐	Dislocations:	_____
☐☐	Fractures:	_____	☐☐	Swelling:	_____
☐☐	Sprains:	_____	☐☐	Surgeries:	_____
☐☐	Strains:	_____	☐☐	X-ray/CAT scan/MRI:	_____

Concussion/head injury - List dates and reasons: _____

Hospitalizations - List dates and reasons: _____

Family history of heart disease or sudden death before age 50 - explain: _____

Family history of Long QT Syndrome or Marfan Syndrome - explain: _____ Height (in): _____

This section must be completed by a US licensed health care provider.

2021-2022 Physical Examination Form

Student's Name: _____ **Grade:** _____

Height (in): _____ Weight (lbs): _____ Temp:_____ Vision - RT:_____ LT: _____

O_2 Sat: _____ Blood Pressure: _____ Resting Pulse: _____ Hearing - RT:_____ LT: _____

CLINICAL FINDINGS

Posture/gait: _____

Skin, hair, scalp:_____

EENT:_____

Teeth/mouth: _____

Neck/thyroid: _____

Heart:_____

Lungs/chest: _____

Abdomen: _____

Groin/genitals: _____

Anus/rectum: _____

Back/extremities: _____

Glands: _____

Neurological:_____

Psycho-social: _____

Nutrition:_____

Menses: _____

Functional/Duck-walk/Single leg hop: _____

OTHER CONCERNS

Any health conditions that should be called to our attention:_____

_____

Allergies: _____

_____

Medications: _____

_____

Physical restrictions/reasons:_____

_____

Sports/PE restrictions/reasons:_____

_____

Diet restrictions/reasons: _____

_____

PHYSICIAN INFORMATION

Signature of examiner: _____Print name: _____

Address: _____U.S. license #: _____

Phone: _____ Fax: _____Date of exam: _____

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2021-2022 IMMUNIZATION RECORD

Student's name: _____ Date of birth: _____

Please have your health care provider complete and sign this form in full. *Please also include all immunizations from birth.* If record is not in English, provide a translated copy along with the original copy signed by your doctor or health care provider.
Note: Indicated below are the State of Hawai'i required number of doses for each vaccine.

Students with *religious immunizations exemptions* are required to fill out the Request Religious Exemption below.

REQUIRED VACCINATIONS

This form will need to be uploaded to Magnus Health by August 1.

Vaccination	Dose #	Type of Vaccine or Brand	Date Given (M/D/YY)
Dtap, DTP, DTs, Diptheria, Tetanus, Pertussis, Specify DTaP, DTP, or DT Booster every 5-10 yrs ***5 doses required***	1		1
	2		2
	3		3
	4		4
	5		5
	6		
	7		
Polio Specify IPV or OPV ***4 doses required***	1		1
	2		2
	3		3
	4		4
MMR Mumps, Measles, Rubella ***2 doses required***	1		1
	2		2
	3		
	4		
Hepatitis B ***3 doses required***	1		1
	2		2
	3		3
Varivax/Varicella (Chicken Pox) ***1-2 doses required or disease date***	1		
	2		

Vaccination	Dose #	Type of Vaccine or Brand	Date Given (M/D/YY)
Hepatitis A ***2 doses required***	1		1
	2		2
Meningococcal MenACWY ***2 doses required***	1		1
	2		2
	3		
	4		
HPV-Gardisil ***2-3 doses required***	1		1
	2		2
	3		3
COVID-19 (SARS-CoV-2) ***recommended***	1		1
	2		2

TB Clearance	(M/D/YY)	Result
TB Risk Assessment		
PPD		
X-Ray		
QuantiFERON TB Gold		
BCG		

_____ _____
Health Care provider signature: Date:

REQUEST FOR RELIGIOUS EXEMPTION

☐ I request an exemption from immunization requirements for my child because immunization is contrary to my religious beliefs:

I understand that my child is susceptible to vaccine preventable diseases. If at any time there is, in the opinion of the Department of Health, danger of an epidemic from communicable disease for which immunization is required, this exemption from the immunization shall not be recognized. I understand that my child will be excluded from school until the threat of an epidemic is over, or until they receive the proper immunization. (Hawai'i Revised Statutes §302-1157)

_____ _____ _____
Church or Religious Group: Signature of Parent or Legal Guardian requesting religious exemption: Date:

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2021-2022 TUBERCULOSIS (TB) RISK ASSESSMENT

A TB Risk Assessment is required of all new students. Please fill out the *TB Document G: State of Hawai'i TB Risk Assessment for Adults and Children Questionnaire*, along with the *TB Document F: State of Hawai'i TB Clearance* form. ***If your child has traveled to (or lived in) a high risk country for four weeks or longer a PPD test will need to be performed by a U.S. licensed medical provider.***

Provider name with license/degree:	Person's name and DOB:
TB Screening date:	Name and relationship of person providing information:

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

This section must be completed by a US licensed health care provider.

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

☐ Yes ☐ No

Does this person have significant TB symptoms?
Significant symptoms include cough for 3 weeks or more, plus at least one of the following:

☐ Coughing up blood ☐ Fever ☐ Night sweats
☐ Unexplained weight loss ☐ Unusual weakness ☐ Fatigue

2. Check for TB Risk Factors

- If any "Yes" box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked "No", then TB clearance can be issued without testing

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
☐ Yes ☐ No	**Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?**
☐ Yes ☐ No	**At any time has this person been in contact with someone with *infectious TB disease*? (Do not check "Yes" if exposed only to someone with latent TB)**
☐ Yes ☐ No	**Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?** *(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)*
☐ Yes ☐ No	**For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?**

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

Signature or unique stamp of *US licensed health care provider*

Printed name *US licensed health care provider*

Healthcare Facility

HIGH RISK COUNTERIES FOR TB:

If your child has traveled to (or lived in) a high risk country for four weeks or longer a PPD test will need to be performed by a U.S. licensed medical provider.

TB Document J: State of Hawaii List of High Risk Countries

Hawaii State Department of Health
Tuberculosis Control Program

Africa		
Algeria	Ethiopia	Niger
Angola	Gabon	Nigeria
Benin	Gambia	Rwanda
Botswana	Ghana	Sao Tome and Principe
Burkina Faso	Guinea	Senegal
Burundi	Guinea-Bissau	Seychelles
Cameroon	Kenya	Sierra Leone
Cape Verde	Lesotho	South Africa
Central African Rep.	Liberia	Swaziland
Chad	Madagascar	Togo
Comoros	Malawi	Uganda
Congo	Mali	United Rep. of Tanzania
Côte d'Ivoire	Mauritania	Zambia
Dem. Rep. of the Congo	Mauritius	Zimbabwe
Equatorial Guinea	Mozambique	
Eritrea	Namibia	
Eastern Mediterranean		
Afghanistan	Libyan	South Sudan
Djibouti	Morocco	Sudan
Iran	Pakistan	Tunisia
Iraq	Qatar	Yemen
Kuwait	Somalia	
Europe		
Armenia	Kazakhstan	Russian Federation
Azerbaijan	Kyrgyzstan	Tajikistan
Belarus	Latvia	The Former Yugoslav
Bosnia - Herzegovina	Lithuania	Turkey
Bulgaria	Poland	Turkmenistan
Estonia	Portugal	Ukraine
Georgia	Republic of Moldova	Uzbekistan
Greenland	Romania	
South-East Asia		
Bangladesh	Indonesia	Sri Lanka
Bhutan	Maldives	Thailand
Dem. People's Rep. of Korea	Myanmar	Timor-Leste
India	Nepal	

The Americas		
Anguilla	El Salvador	Paraguay
Argentina	Guatemala	Peru
Belize	Guyana	Saint Vincent - Grenadines
Bolivia	Haiti	Suriname
Brazil	Honduras	Trinidad and Tobago
Colombia	Mexico	Turks and Caicos Islands
Dominican Republic	Nicaragua	Uruguay
Ecuador	Panama	Venezuela
Western Pacific		
Brunei Darussalam	Lao People's Dem. Rep.	Papua New Guinea
Cambodia	Malaysia	Philippines
China	Marshall Islands	Republic of Korea
China, Hong Kong SAR	Micronesia (Fed. States of)	Singapore
China, Macao SAR	Mongolia	Solomon Islands
Fiji	Nauru	Tuvalu
French Polynesia	New Caledonia	Vanuatu
Guam	Niue	Viet Nam
Japan	Northern Mariana Islands	Wallis and Futuna Islands
Kiribati	Palau	

High-incidence countries include any country with an annual TB rate over 20/100,000.
Source: http://www.who.int/tb/country/data/download/en/
Revised Oct 2016.

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TUBERCULIN SKIN TEST – PPD

to be completed by HPA Health Services

Name: _____ DOB: ____ /____ /_____ Phone: _____

Date given: _____ /_____ /_____ Site given: ☐ LF ☐ RF Time given: ____:____ Admin by: _____

Date read: _____ /_____ /_____ Time read: ____:____ Read by:_____ Result: _____mm of induration

History BCG: _____ X-ray date: _____ Result: _____

MD signature: _____