# PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

*(Physical must be done in enrollment year and be on file in the health office by August 1st)*

Student Name: _____

Date of Birth:_____ Age:_____ Sex:_____

Height:_____ Weight:_____ Blood Pressure:_____ Pulse:_____

Allergies:_____

**Physical Examination: Explain all positive findings in the space below**

| | | | | | |
|---|---|---|---|---|---|
| Skin(including scars, surgeries) | Positive: _____ | Negative: _____ | Hernia: | Positive: _____ | Negative: _____ |
| Head/Neck (including eyes, ears, teeth) | Positive: _____ | Negative: _____ | Musculoskeletal | Positive: _____ | Negative: _____ |
| Gums, nasal problems, thyroid: | Positive: _____ | Negative: _____ | Heart: | Positive: _____ | Negative: _____ |
| Nutrition: | Positive: _____ | Negative: _____ | Gastrointestinal: | Positive: _____ | Negative: _____ |
| Throat: | Positive: _____ | Negative: _____ | Neurologic: | Positive: _____ | Negative: _____ |
| Thorax: | Positive: _____ | Negative: _____ | Metabolic / Endocrine: | Positive: _____ | Negative: _____ |
| Lungs: | Positive: _____ | Negative: _____ | Extremeties: | Positive: _____ | Negative: _____ |
| Genito - Urinary: | Positive: _____ | Negative: _____ | Allergies: | Positive: _____ | Negative: _____ |

**Please explain any positive findings in detail including symptoms and treatment:**

_____

_____

**Is the student currently under physician's treatment for any known condition? Yes____ No____**

If so, elaborate: _____

**Will the applicant be taking any prescription medications in the US?** *If yes, please complete the medication form attached.*

**State of applicant's health: Excellent Good Fair Poor**

**Do you clear this student to participate in athletics? Yes_____ No_____**

**I have reviewed the medical history of this applicant and completed a thorough physical examination. I hereby certify that all relevant medical information has been included and that the above information is complete and accurate. In my judgement, it provides all available information that might prove necessary to those responsible for his/her health care in the US. The student is physically able to engage in a full high school program, including athletics, physical education, and all other school activities without restriction.**

**Physician's name (please print):**_____

**Physician's Signature:**_____ **Date:**_____



81 Acadeny Hill, Newcastle, ME 04553, Phone: 207.563.3596, FAX: 207.563.1067, EMAIL: ferrante@lincolnacademy.org, URL: www.lincolnacademy.org

# Lincoln Academy Health History

**Student name:_____ Date of Birth:_____ Country:_____**

**To be completed by student's parents/guardian and provided to physician prior to completion of Physician's Report of Physical Examination (Questions 6-69, if answered "YES" are to be fully explained)**

## HAS THE STUDENT EVER HAD OR NOW HAS ANY OF THE FOLLOWING:

| CHILDHOOD DISEASES | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| 1. Chickenpox | | | 27. Foot trouble | | | 53. Rectal disease, piles | | |
| 2. German Measles | | | 28. Gum or mouth trouble | | | 54. Tonsillectomy, throat problems | | |
| 3. Measles | | | 29. High or low blood pressure | | | 55. Thyroid trouble or goiter | | |
| 4. Mumps | | | 30. Neuralgia, neuritis or sciatica | | | 56. Tuberculosis or other lung issues | | |
| 5. Whooping Cough | | | 31. Phlebitis, varicose veins | | | 57. Ulcer, stomach or duodenal | | |
| **HISTORY** | | | 32. Speech difficulties, stutter or stammer | | | 58. Glasses - BRING PRESCRIPTION | | |
| 7. Back Trouble | | | 33. Stomach or intestinal trouble | | | 59. Contacts - BRING PRESCRIPTION | | |
| 8. Bed Wetting | | | 34. Weight, recent loss or gain (anorexia or bulimia) | | | 60. Hearing aids | | |
| 9. Hernia or rupture | | | 35. Anemia or other blood disease | | | 61. Any hospitalizations? | | |
| 10. Malaria | | | 36. Amnesia or loss of memory | | | 62. Any surgeries? | | |
| 11. Meningitis | | | 37. Arthritis, joint trouble | | | 63. Dental braces? | | |
| 12. Mononucleosis | | | 38. Asthma, breathing trouble | | | 64. Other injuries? | | |
| 13. Motion Sickness | | | 39. Frequent ear infections | | | | | |
| 14. Nasal problems; Sinusitis | | | 40. Cancer, tumor, cyst or growth | | | **MENTAL HEALTH** | | |
| 15. Nightmares, insomnia | | | 41. Colitis, enteritis | | | 65. Anxiety | | |
| 16. Scarlet Fever | | | 42. Concussion, unconsciousness, or head injury | | | 66. Emotional problems | | |
| 17. Migraines/frequent headaches | | | 43. Diabetes | | | 67. Personality disorder | | |
| 18. Bone, joint or other deformities | | | 44. Eczema or other skin issue | | | | | |
| 19. Chronic cough, recurrent colds | | | 45. Epilepsy or other aspastic condition | | | **ALLERGIES: (MEDICATION, ENVIRONMENTAL)** | | |
| 20. Chest pain &/or pressure | | | 46. Hearing Difficulty | | | | | |
| 21. Cramps in legs | | | 47. Heart trouble, murmur, palpitations, racing | | | | | |
| 22. Chronic diarrhea | | | 48. Hepatitis or liver trouble, jaundice | | | | | |
| 23. Difficulty with coordination / walking | | | 49. Kidney trouble, frequent urination | | | | | |
| 24. Dyslexia, or other reading problems | | | 50. Attention issues / hyperactivity | | | | | |
| 25. Eye trouble | | | 51. Poliomyelitis | | | | | |
| 26. Fainting episodes or convulsions | | | 52. Rheumatic fever | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**Please explain any "Yes" answers below**

| |
|---|
| |

**Physician's name (please print):_____**

**Physician's Signature:_____ Date:_____**

**Parent's name (please print):_____**

**Parent's Signature:_____ Date:_____**



81 Acadeny Hill, Newcastle, ME 04553, Phone: 207.563.3596, FAX: 207.563.1067, EMAIL: ferrante@lincolnacademy.org, URL: www.lincolnacademy.org

**Lincoln Academy**
**Immunization Requirements**

**Student name:_____ Date of Birth:_____**

*Maine Law requires form to be completed and returned to Lincoln Academy prior to Student's arrival. Immunizations are meant to protect the entire population and should not be taken lightly.*

**Please submit documentation by August 1st if entering in September or 3 weeks prior to anticipated start date if entering after September 15th, or January 3rd.**

***The following immunizations are mandatory. Documentation must be received prior to entering school.***

**Vaccination History**: Enter the month, day and year of each immunization given. Note that in the United States, dates are written as follows: **month/day/year**

| **STATE OF MAINE REQUIRED IMMUNIZATIONS** | |
|---|---|
| **DPT/DTaP/Td (Diptheria/Tetanus/Pertussis)** | At least **4 doses** with the last dose given at the age of 4 years or older |
| **Tdap booster** | A dose given in the past 10 years |
| **Polio** | At least **3 doses** with the first dose at least 6 weeks old and the last dose given after 4 years of age |
| **MMR(Measles, Mumps, Rubella)** | 2 doses of MMR with the first dose given on or after age one |
| **Varicella (chicken pox)** | Medical documentation of the disease OR two doses of Varicella vaccine |
| **LINCOLN ACADEMY REQUIRED VACCINATIONS** | |
| **COVID** | 2 Doses AND booster if 6 months since second dose (PLEASE SUBMIT COPY OF OFFICIAL VAX CARD) |
| **Menactra (Meningitis)** | 1 dose is required upon entering 9th grade with a booster at 16 years of age |
| **Influenza (Flu vaccine)** | Administered at Lincoln Academy annually |
| **HIGHLY RECOMMENDED VACCINATIONS** | |
| **Hepatitis B** | 3 doses |
| **Hepatitis A** | 2 doses |



81 Acadeny Hill, Newcastle, ME 04553, Phone: 207.563.3596, FAX: 207.563.1067, EMAIL: ferrante@lincolnacademy.org, URL: www.lincolnacademy.org

# STUDENT IMMUNIZATION RECORD

**Student name:_____ Date of Birth:_____**

| **IMMUNIZATIONS** | **1st dose** month/day/year | **2nd dose** month/day/year | **3rd dose** month/day/year | **4th dose** month/day/year | **5th dose** month/day/year |
|---|---|---|---|---|---|
| **DPT/DTaP/Td** | | | | | XXXXXXXX |
| **Tdap booster** | XXXXXXXX | XXXXXXXX | XXXXXXXX | XXXXXXXX | |
| **Polio** | | | | | XXXXXXXX |
| **MMR (measles,mumps,rubella)** | | | XXXXXXXX | XXXXXXXX | XXXXXXXX |
| **Varicella (chicken pox)** | | | XXXXXXXX | XXXXXXXX | XXXXXXXX |
| **COVID** | | | | XXXXXXXX | XXXXXXXX |
| **Menactra (Meningitis)** | | | XXXXXXXX | XXXXXXXX | XXXXXXXX |
| **Hepatitis B** | | | | XXXXXXXX | XXXXXXXX |
| **Hepatitis A** | | | XXXXXXXX | XXXXXXXX | XXXXXXXX |

***Laboratory confirmation of immunity is only acceptable for Measles, Mumps, Rubella and Varicella. A laboratory report must be provided.***

**Verification of Varicella disease(Chicken pox) :**

Chicken Pox Disease : _____ Date of Disease:_____

**TB (Tuberculin test) Mantoux (ppd) -**

Date given:_____ Result: ___ negative ___ positive _____mm induration

If positive, Chest x-ray date:_____ Results of Chest x-ray:_____

**I CERTIFY THAT THIS STUDENT HAS RECEIVED THE IMMUNIZATIONS INDICATED ABOVE:**

**Physician's name (please print):_____**

**Physician's Signature:_____ Date:_____**

**Student name:_____ Date of Birth:_____**



81 Acadeny Hill, Newcastle, ME 04553, Phone: 207.563.3596, FAX: 207.563.1067, EMAIL: ferrante@lincolnacademy.org, URL: www.lincolnacademy.org

## Lincoln Academy Guidelines for Residential Medication Administration

The following is a list of guidelines that must be signed and followed for any medication to be administered at Lincoln Academy.

1. The school nurse must have written notification from the student's healthcare provider when a medication is to be administered at school. This must include: Name of medication, condition being treated, dosage and times to be administered.
2. All medication must be in its original container with the label intact. Whenever possible, the label should be in English. If not, translation should be provided to the nurse.
3. All medication will be supplied to the nurse, either in person or through the mail in a timely fashion. Deviation may cause a delay or interruption in receiving the medication. You may use a local pharmacy.
4. All medications must be administered by or under the direction of the nurse or trained staff on duty. All medication must be stored in the Health Center. This includes all over the counter medications, prescriptions and anything that appears to be or takes the form of medicine. Students may be given permission to self-administer certain medications in the dormitory. Examples include antibiotic ointments and cleansers for acne, inhalers for asthma, certain allergy medication and vitamins.
5. When students are sick at Lincoln Academy, it is often wise to provide them with over the counter medication for symptom relief. The dorm trained staff on duty, with assistance of the nurse, may decide which medications are useful not requiring a healthcare provider's evaluation. If there are any medications your child should not take, please list them here.

_____

_____

6. Students are not allowed to keep medication in their rooms unless given permission by the school nurse as stated above.
7. Students may not be sent antibiotics or other prescription medications from home to keep in their rooms. All medication must be screened by the Health Center.
8. Over the counter (OTC) medication should not be kept in the dormitory unless previously approved or provided by the Health Center.
9. The Health Center has a school physician who has written a formulary of approved over the counter medication that may be given to residential students.
10. Lincoln Academy can not assume responsibility for the medication needs of your child when traveling outside the supervision of the school. Lincoln Academy will provide medications to the students leaving campus for weekends or breaks, provided that the parent/guardian has signed this authorization to do so and the medication is available. I assume all responsibility for the medication from the time given to my child, until it is returned to the nurse or dorm staff of Lincoln Academy.

**Name of Student:**_____ **Date of Birth:**_____

**Student Signature:**_____ **Date:**_____

**Parent Signature:**_____ **Date:**_____



81 Acadeny Hill, Newcastle, ME 04553, Phone: 207.563.3596, FAX: 207.563.1067, EMAIL: ferrante@lincolnacademy.org, URL: www.lincolnacademy.org

## PERMISSION TO GIVE PRESCRIPTION MEDICATION AT SCHOOL

Please list all prescribed and over the counter medications your child receives. This includes medications taken for temporary illness and even over the counter medicines, which, according to a physician's orders, must be taken at a higher dosage than the recommended packaging. The prescribing physician must sign and provide administration directions. The student should bring at least a one month supply when he/she arrives at school.

**Student's full name:_____ Date of Birth:_____**

_____ This student takes NO medication on a routine basis.

_____ This student takes the following medication.

### TO BE FILLED OUT AND SIGNED BY PRESCRIBING PHYSICIAN/DENTIST

Name of Medication:_____ Dosage:_____

Specific time to be administered: _____

Reason for taking:_____

Length of time:_____ Every day:_____ School days only:_____

Printed name of Physician/Dentist:_____

Signature of Physician/Dentist:_____

Telephone number :_____ Date:_____

### TO BE FILLED OUT BY PARENT/GUARDIAN

**PERMISSION TO GIVE MEDICATION: a separate form must be used for each medication. Copy as needed.**

My child is permitted to receive the above medication as directed.

Printed name of parent/guardian:_____

Signature of parent/guardian:_____

Telephone number :_____ Date:_____

**Do you give permission for your child to receive over the counter medications such as:**

| | | |
|---|---|---|
| Acetaminophen (fever reducing medication) | Yes _____ | No _____ |
| Non-steroidal anti-inflammatory | Yes _____ | No _____ |
| Antacid | Yes _____ | No _____ |
| Decongestant | Yes _____ | No _____ |
| Medicinal Teas | Yes _____ | No _____ |
| Antihistamine/Allergy Relief | Yes _____ | No _____ |



81 Acadeny Hill, Newcastle, ME 04553, Phone: 207.563.3596, FAX: 207.563.1067, EMAIL: ferrante@lincolnacademy.org, URL: www.lincolnacademy.org