THE EXPERIMENTORY AT DEERFIELD ACADEMY

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Form 3: Healthcare Provider's Report

Name MICHAEL EBOSO **Sex** M **DOB** 9/8/2005

Physical Measurements

Height 5'0.63" Weight 101 lbs 6.4 oz BMI _____ date 4-19-18

Blood Pressure 90/60 Heart Rate 76 date 4-19-18

Vision uncorrected: OD 20/ 20 OS 20/ 20 date 4-19-18

Vision corrected: OD 20/ _____ OS 20/ _____ date _____

Laboratory Data

Hemoglobin/hematocrit: 13.9 / 37.3 (Hct) date 2/20/17

Cholesterol (optional): _____ date _____

Physical Examination

	Normal	Abnormal findings
Skin		
HEENT		
Neck		
Heart		
Lungs		
Abdomen		
Genitalia		
Musculoskeletal:		
Back		
Upper extremities		
Lower extremities		

TB Risk Assessment And Testing

☐Yes ☒No Does this student have a history of close contact with a person with active TB?

☐Yes ☒No Was this student born in a country with a high prevalence of TB (Africa, Middle East, Asia except Japan, Central/South America, Caribbean, Mexico, and Eastern Europe)?

☐Yes ☒No Has this student lived or had extensive travel (> 4 weeks) within the past 5 years in a high prevalence country?

If the answer to any question above is "Yes," a TB Skin Test or TB Blood Test is required within the last year. If all the answers are "No," provide any TB test results that are available, but a new TB test is not required. If a TB test is positive, please provide a chest X-ray report and details of any drug treatment below.

	DATE	RESULT		DATE	RESULT
Skin Test			**CXR**		
Blood test (circle one) QFT–GIT or T–Spot			**Treatment details**		

1. Is this student capable of a competitive athletic program? ☒Yes ☐ No
   Any restrictions?
2. Does this student have any chronic medical conditions (e.g., asthma, acne, diabetes, migraine)? ☐ Yes ☒No
   If yes, please describe:
3. Does this student have a history of attention deficit disorder, eating disorder, depression, obsessive-compulsive disorder, bipolar disorder or substance abuse? ☐ Yes ☒No
   If yes, please describe:
4. Allergies? NKA
5. Has this student ever experienced a life-threatening allergic reaction? ☐ Yes ☒No
   If yes, please describe:

   If yes, has this student been instructed in the use of self-administered epinephrine? ☐ Yes ☐ No
6. Medications taken regularly and/or intermittently:

Signature of Healthcare Provider _____ **Date** 4/19/18

Print Name Sara H. Mullan, M.D. **Phone**

Address Pediatric Department, 444 Montgomery Street, Chicopee, MA 01020, Phone: (413) 598-7040, Fax: (413) 598-7011

RiverBend MEDICAL GROUP

Rev.3/17

Immunization Record

See attached

STUDENT NAME: Michael Ebos **DOB:** 9/8/05

Documentation, including the month, day and year (mm/dd/yy) is required by law.

REQUIRED IMMUNIZATIONS	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DPT or DTaP					
OPV or IPV					
DT or Td				Tdap →	Dose 1
Hepatitis B					
Meningococcal Vaccine					
MMR					
Measles (Rubeola)			or Measles serology: Date_____ Titer_____		
German Measles (Rubella)			or Rubella serology: Date_____ Titer_____		
Mumps			or Mumps serology: Date_____ Titer_____		
Chicken pox (Varicella)			Physician-certified reliable history of varicella: ☐ Yes ☐ No		
OPTIONAL IMMUNIZATIONS	Dose 1	Dose 2	Dose 3		
HPV					
Hepatitis A					
Typhoid (please indicate oral or injection)					
Other					

Massachusetts School Immunization Requirements

	Kindergarten	Grades 1-6	Grades 7-12
Hepatitis B	3 doses	3 doses	3 doses
DTaP/DTP/DT/ Td/Tdap	≥4 doses DTaP/DTP	5 doses DTaP/DTP	4 doses DTaP/DTP or >3 doses Td; plus 1 dose Tdap
Polio	4 doses	≥3 doses	≥3 doses
MMR	2 doses	2 doses	2 doses
Varicella	2 doses	2 doses	2 doses
Meningococcal	NA	NA	1 dose for new full-time boarding students

☆ **Signature of Healthcare Provider** A. Tha **Date** 4-5-18

Print Name RiverBend MEDICAL GROUP **Phone**

Address ~~Sara H. Mullan, M.D.~~ Rev.3/17

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