2021- 2022 CONFIDENTIAL STUDENT HEALTH HISTORY

Parents/Guardians: Please submit the completed form to your student Magnus Health Record located on the Parent/Guardian myCushing Portal. Please submit technical concerns regarding Magnus Health by email to: tech@cushing.org

THIS FORM IS MANDATORY YEARLY FOR ALL STUDENTS
Must be completed by a primary care provider.

STUDENT NAME (please print): _____ Date of Birth: _____
FIRST MIDDLE LAST MONTH/DAY/YEAR

GENDER IDENTITY: ☐ Male ☐ Female ☐ Intersex ☐ Transgendered ☐ Decline to answer

GENDER ASSIGNED AT BIRTH: ☐ Male ☐ Female ☐ Decline to answer

Do you consider this student to be in good health? ☐ Yes ☐ No

VITAL SIGNS & GROWTH:	**ALLERGIES:**	**CURRENT MEDICATIONS:**
P_____ BP _____/_____ RR _____ HT _____ WT _____ BMI _____	☐ NONE ☐ YES (List all food, medication and environmental allergies) _____ ☐ Mild ☐ Moderate ☐ Severe _____ ☐ Mild ☐ Moderate ☐ Severe _____ ☐ Mild ☐ Moderate ☐ Severe _____ ☐ Mild ☐ Moderate ☐ Severe _____ ☐ Mild ☐ Moderate ☐ Severe _____ ☐ Mild ☐ Moderate ☐ Severe	List all including vitamins and supplements. _____ _____ _____ _____ _____ _____ _____ _____

PAST MEDICAL HISTORY:

Major Illness/Hospitalized?	☐ No	☐Yes, Description & Year(s): _____
Physical Trauma?	☐ No	☐Yes, Description & Year(s): _____
Concussion/Head Injury?	☐ No	☐Yes, Description & Year(s): _____
Surgery?	☐ No	☐Yes, Description & Year(s): _____
Musculoskeletal?	☐ No	☐Yes, Description & Year(s): _____
Diabetes?	☐ No	☐Yes, Description & Year(s): _____
Seizure?	☐ No	☐Yes, Description & Year(s): _____
Anaphylaxis?	☐ No	☐Yes, Description & Year(s): _____
Asthma?	☐ No	☐Yes, Description & Year(s): _____
Mental Health?	☐ No	☐Yes, Description & Year(s): _____
Learning Concerns?	☐ No	☐Yes, Description & Year(s): _____
Social Concerns?	☐ No	☐Yes, Description & Year(s): _____
Chicken Pox?	☐ No	☐Yes, Description & Month/Year: _____
COVID 19?	☐ No	☐Yes, Description & Month/Year): _____
Recurrent Problem(s)?	☐ No	☐Yes, Description & Year(s): _____

_____
_____
_____

Cushing Academy Health Services • 39 School St. Ashburnham, MA 01430-8000 USA • Phone: (978) 827-7111 • Fax: (978) 827-7147 • Email: healthcenter@cushing.org

SIGNIFICANT FAMILY HISTORY:

Mother: _____
Father: _____
Sibling(s): _____
Sudden or traumatic death under the age of 45? ☐ Yes ☐ No

PHYSICAL EXAM

For each system check normal or abnormal. Please describe any abnormalities in the comment section.

Date of Last Examination: _____

General:	☐ NI	☐Abnl	Comment: _____
Head:	☐ NI	☐Abnl	Comment: _____
Eyes:	☐ NI	☐Abnl	Comment: _____
Ears:	☐ NI	☐Abnl	Comment: _____
Nose:	☐ NI	☐Abnl	Comment: _____
Oral/Pharynx:	☐ NI	☐Abnl	Comment: _____
Dental:	☐ NI	☐Abnl	Comment: _____
Neck:	☐ NI	☐Abnl	Comment: _____
Heart/CV:	☐ NI	☐Abnl	Comment: _____
Lungs:	☐ NI	☐Abnl	Comment: _____
Abdomen:	☐ NI	☐Abnl	Comment: _____
Neurologic:	☐ NI	☐Abnl	Comment: _____
Extremities:	☐ NI	☐Abnl	Comment: _____
Back:	☐ NI	☐Abnl	Comment: _____
Skin:	☐ NI	☐Abnl	Comment: _____
GU & GYN:	☐ NI	☐Abnl	Comment: _____

SCREENING:

Vision: Right Eye ☐ Pass ☐ Fail
Left Eye ☐ Pass ☐ Fail
Stereopsis ☐ Pass ☐ Fail

Hearing: Right Ear ☐ Pass ☐ Fail
Left Ear ☐ Pass ☐ Fail
Postural Screen: ☐ Pass ☐ Fail

STATUS & RECOMMENDATIONS

(must CHECK ONE box)

☐ Well adolescent **CLEARED** to **participate FULLY**
No restrictions to academics, athletics, or extracurriculars. **No specific recommendations** for care or support of this student

☐ Well adolescent **CLEARED** to **participate WITH RESTRICTIONS**
Academic, athletic, and/or extracurricular restrictions noted here:
_____

☐ Well adolescent **CLEARED** to **participate WITH SUPPORTS**
Specific recommendations for care or support noted here:
_____

☐ **NOT CLEARED** to **participate for reasons noted here:**
_____

PROVIDER'S PRINTED NAME: _____ **OFFICE PHONE:** _____

PROVIDER'S SIGNATURE: _____ **DATE:** _____

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