

**HEALTH HISTORY & PHYSICAL EXAMINATION FORM**  
 The Putney School ■ Health Services ■ 418 Houghton Brook Rd. ■ Putney, VT 05346



To be completed by a licensed medical practitioner not related to the student and who has examined the student no more than one year prior to registration.

Student Name: \_\_\_\_\_

**Health History - Check any of the following medical conditions the student has had:**

	Age	Treatment		Age	Treatment
Anemia or other blood problem	_____	_____	Headaches, frequent	_____	_____
Asthma	_____	_____	Insomnia	_____	_____
Diabetes	_____	_____	Malaria	_____	_____
Emotional Problems	_____	_____	Respiratory Problems	_____	_____
GI Problem(chronic)	_____	_____	Seizure disorder	_____	_____
			Tuberculosis	_____	_____

List allergies to medications: \_\_\_\_\_

List environmental allergies: \_\_\_\_\_

List surgeries with dates: \_\_\_\_\_

List hospitalizations with dates: \_\_\_\_\_

Other significant medical conditions: \_\_\_\_\_

If any interruption of scholastic career, please state conditions: \_\_\_\_\_

To your knowledge, has this student experienced or been treated for an emotional, behavioral, and/or social difficulty in the past 2 years (e.g., parental divorce, relocation, substance abuse, or other unusually stressful situations)? Yes \_\_\_\_\_ No \_\_\_\_\_.

If yes, please describe: \_\_\_\_\_

Has the student had any emotional symptoms such as mood swings, depression, or unusual degree of anxiety or guilt? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

**Immunizations: Please give date of each immunization.**

Diphtheria, Tetanus, Pertussis (Tdap) and Boosters. Minimum of three doses and boosters every ten years. (Give month and year)				
1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Booster	Booster

Polio. Minimum 3 doses		
1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>

Measles, Mumps and Rubella. (2 doses)		Hepatitis B. (3 doses)		
1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>

Meningococcal (1 dose)		Varicella (2 doses)		
		1 <sup>st</sup>	2 <sup>nd</sup>	
Hepatitis A (2 doses)		HPV (women only)		
1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>

Other Immunizations


Does the student have any contraindication to a flu vaccination/flu mist? Yes \_\_\_\_\_ No \_\_\_\_\_

Physician signature \_\_\_\_\_

Date \_\_\_\_\_

**Physical Exam:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Eyes: \_\_\_\_\_

Vision uncorrected: Rt: \_\_\_\_\_ Left: \_\_\_\_\_ Prescription for Glasses: \_\_\_\_\_

Contact lenses? \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_

Ears: Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Any Abnormality? \_\_\_\_\_

Nose and Throat \_\_\_\_\_

Teeth \_\_\_\_\_ Gums \_\_\_\_\_ Date of last Dentistry \_\_\_\_\_

Neck: (thyroid size, enlarged nodes, etc.) \_\_\_\_\_

Chest: (size, symmetry, etc.) \_\_\_\_\_ Lungs: \_\_\_\_\_

Heart: Rhythm \_\_\_\_\_ Any murmur? \_\_\_\_\_ Neurological Abnormalities: \_\_\_\_\_

Abdomen: (scars, masses, hernia, etc.) \_\_\_\_\_

Orthopedic: \_\_\_\_\_ Skin: (acne, etc.) \_\_\_\_\_ External Genitalia \_\_\_\_\_

Do you recommend referral to any specialty service? \_\_\_\_\_

Do you envision any need to make provisions and/or limitations in the student's pursuit of a vigorous academic, extra-curricular, and/or sports/travel program? Yes \_\_\_ No \_\_\_ If yes, please describe:

To your knowledge, has this student been in the care of a mental health professional(s) in the past two years? Yes \_\_\_ No \_\_\_

**If yes, a Mental Health Report (included) must be completed by the mental health professional.**

Does student regularly take medication of any type including psychotropic medication or birth control pills? Yes \_\_\_ No \_\_\_

Please list all regularly scheduled medications (with dosage) and **complete a medication order sheet (included) for each prescription** the student will take while at school. It is important for us to be aware of all medications students are taking in the event of an emergency at school. This includes day students who take medications at home.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are asked to urge this student to have remedied, BEFORE ENTERING THE PUTNEY SCHOOL, any condition likely to cause interruption in success at The Putney School program.

Please use a separate sheet to include further information or elaborate on any condition above.

\_\_\_\_\_  
Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Physician name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

**Return to:** The Putney School Summer Programs  
418 Houghton Brook Road  
Putney, VT 05346-8675 USA  
Phone 802-387-6297 • Fax 802-387-6216



## PRESCRIPTION MEDICATION ORDER & PERMISSION

Prescription Medication will not be given to students at school until the Health Center receives this form completed and signed by the prescribing physician. The medication must be in its original container labeled by the pharmacy as prescribed by the physician. All regularly scheduled medications must be listed here and on the Permission to Treat Form so that, in the event of an emergency, the treating physician is aware of all medications. Complete one form for **EACH** medication.

Name of Student: \_\_\_\_\_

Medication: \_\_\_\_\_

Directions: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

\_\_\_\_\_  
Physician name (print please)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date

Return with Health History & Physical Examination Form to:

The Putney School Summer Programs

418 Houghton Brook Rd.

Putney, VT 05346 USA

Phone: 802-387-6297 Fax: 802-387-6216



## MENTAL HEALTH REPORT

*This report is to be filled out by all mental health professionals that have provided services to the student within the past two years. (Copy form if necessary)*

**Name of student:** \_\_\_\_\_

To the Mental Health Professional: This student has already been accepted to Summer Programs at The Putney School. In an effort to provide the most comprehensive services possible, it is important that we know of any emotional difficulties the student has had, should any mental health issues arise in our rigorous boarding school environment. Thank you for completing the following:

When and for how long did you see the student?

What were the presenting issues and the DSM IV diagnosis?

What treatment was provided and how would you assess the outcome?

Was/is medication prescribed and if so, what?

List all hospitalizations:

Hospital	Dates	Outcome

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print name \_\_\_\_\_

License / Title / Degree \_\_\_\_\_

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