UNC Music Workshop

2020 Workshop Health Form

Participant's Full Name _____

Participant's Date of Birth _____

THIS FORM TO BE COMPLETED BY A PHYSICIAN

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS CHILD:

1. Is physically fit to engage in strenuous activities without harm to himself/herself or others.
2. Has no significant infectious condition that could be transmitted to others.
3. Has no emotional or physical disorder that could not be cared for under the routine operations and programs of the Workshop. Some special conditions may be handled after individual discussions with the UNC Music Workshop.

Weight: _____ Height: _____ B.P. _____

Code: (If normal, leave box blank; If abnormal, check the box and explain)

☐ Skin _____ ☐ Nose _____

☐ Chest _____ ☐ Extremities _____

☐ Eyes _____ ☐ Throat _____

☐ Heart _____ ☐ Spine _____

☐ Ears _____ ☐ Teeth _____

☐ Abdomen _____ ☐ Neurologic _____

Menstrual History: _____

Recommendations and restrictions (diet, activity restrictions): _____

_____

Allergies: _____

Does the participant have chronic medical problems, emotional difficulties, eating disorders or behavioral issues of which you are aware?

☐ Yes ☐ No If yes, please describe the condition: _____

_____

Does participant take routine medications or nutritional supplements? ☐ Yes ☐ No If yes, please list medications/nutritional supplements

_____

To coincide with N.C. law for school enrollment, the UNC Music Workshop requires the following immunizations:

*DTP / DTaP/ DT	Date: _____
**dT/TdaP	Date: _____
*Polio (IPV/OPV)	Date: _____
***Hib	Date: _____
****Hepatitis B	Date: _____
*MMR (combined doses)	Date: _____
*****Chicken Pox	Date: _____
**Meningococcal	Date: _____

*Required by NC State law
**Required by State law if child is 12 years or older
***Required by State law for children born on or after 10/01/88
****Required by State law for children born on or after 07/01/94
*****Required by State law for children born on or after 04/01/01

Date of most recent PPD (Mantoux) Test _____

Test results _____

(If indicated according to recommendations in the AAP Red Book

Recommended immunizations in addition to those above:

Pneumococcal	Date: _____
HPV	Date: _____
Hep A	Date: _____
BCG/IPPD	Date: _____

Print or Stamp
Physician's Name
Address
Phone Number

My signature indicates I have reviewed this form as well as examined this patient on _____ Date of Exam
(within 12 months of arrival at Workshop)

Signature of Physician _____