For Nurse Use Only
(initials of clinical personnel completing form _____)

Last weight:

REQUEST FOR MEDICAL/PHYSICAL FORM COMPLETION

Patient Name:_____ **Date of Birth:** _____
Last Name, First Name

Type of Form Needing Completion:
(Please check one)

- **___ Day Care Form**
- **___ School Medication Form**
- **___ Sports Physical Form**
- **___ Kindergarten Assessment**
- **___ Other (specify) _____**

****For Sports Physical Forms, since March, 2020, has the athlete either been diagnosed with COVID OR had a positive COVID test?** YES ☐ NO ☐
(If YES, please ask to speak with a nurse TODAY regarding clinical review for a Cardiac Evaluation/Clearance)

Date Form Dropped off: _____ **Date Form Needed for Pick Up:** _____

Please allow us approximately 5-7 business days for completion of form.

Please list below all medications along with dosage and frequency your child is currently taking.
(Over the Counter and Prescription)

Medication	Dosage	Frequency	Will be taking at Camp	Will Medication be taken at School
_____	_____	_____	YES ☐ NO ☐	YES ☐ NO ☐
_____	_____	_____	YES ☐ NO ☐	YES ☐ NO ☐
_____	_____	_____	YES ☐ NO ☐	YES ☐ NO ☐
_____	_____	_____	YES ☐ NO ☐	YES ☐ NO ☐

Please list a daytime phone number where you may be reached to inform you when form is completed and ready for pick up:

(_____)_____
(area code) Phone Number

_____ _____
Name of Person To Pick up Form Relationship to Patient

If person picking up form is other than patient/parent, please specify full name and relationship. Please be advised that due to our policies regarding the Privacy of Patient Health Information, our staff will ask for a photo ID of person picking up form.

If unable to pick up, would you like us to mail to your home address? YES____ NO____
Please provide us with a **stamped self-addressed envelope**.
Please verify your home mailing address: _____
Street no. (P.O. Box)

_____
City, State Zip

Due to the need for maintaining the privacy of our patient's medical information, we **prefer** that the **form either be picked up or mailed to your home address**. We do understand that extenuating circumstances may occur that would require us to fax the completed form to you. You may request our office to fax the completed form. Please complete below:

_____ _____
Person/Company To Whom to Fax Secured Fax Number

I give my permission to Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A./Clayton Pediatric and Adolescent Medicine to fax the requested form to the person and number specified above. I also give authorization for Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A./Clayton Pediatric and Adolescent Medicine to release completed form to the above named person in the event the patient, parent or legal guardian is unable to pick up.

_____ _____
Signature of Patient, Parent, or Legal Guardian Relationship to Patient