THE JOHN CARROLL SCHOOL

Health and Physical Forms 2019-2020

HEALTH FORMS TO BE COMPLETED

ALL forms must be returned to the school nurse by August 1, 2019.

1. **New Student and Athletic Physical Form:** This form is a very important record while your son/daughter is a student at John Carroll. A physical exam is necessary for all incoming freshmen and transfer students, in addition to each year that a student participates in a sport. This form provides us with necessary information and will be kept confidentially on file in the Nurse's office.
2. **Health History Questionnaire Form:** To be completed by parent and student prior to getting a physical exam.
3. **Medical Update and Discretionary Medication Consent Form:** These are medications, supplied by the school, for students whose parents/guardians have completed and signed this form. These medications will be given by the school nurse or designated RN according to nurse discretion under the protocols approved by the school medical consultant. Please complete form, sign and return even if you do not wish for these medications to be available to your child. In addition, the medical update should be completed to inform the school about any medical concerns the student may have.
4. **MD Department of Health Immunization Certificate:** Use attached vaccine form or send a copy from your son/daughter's physician. Vaccine compliance is mandated by law.
5. **MD State School Medication Administration Authorization Form**: This form is for any medications (not listed on the discretionary medication form) that your child needs to have during the school day. i.e. cold medications, epi pens, inhalers, and other prescription medications. Please make sure **both** physician and parent sign the form. Medication must be in the **original container** with the student's name on the label. Pharmacies can provide a second labeled bottle to accommodate medications that are given in school.

Extra forms are available on The John Carroll website under Current Patriots (Forms and Downloads). Policies concerning medications are stated in the Student Handbook on The John Carroll website under Current Patriots (Student Handbook). Please double check that all of the information spaces are completed.

If you have any questions, please call Michelle Webster, School Nurse, 410-838-8333 ext. 2010 or email her at mwebster@johncarroll.org. Thank you for your cooperation.

Summary of Forms Needed

Title of Form	Date Due	✓ When Completed
1. Physical Form and Health History Questionnaire Completed and signed by parent and physician	August 1, 2019	
3. Medical Update/Discretionary Medication Consent Form Administration consent form completed and signed by parent	August 1, 2019	
2. Maryland Department of Health Immunization Certificate Use this form or one provided by your physician	August 1, 2019	
4. Maryland State School Medication Administration Authorization Form For any medications needed in school not listed on Discretionary Medication Consent Form completed and signed by both parent and physician if needed	August 1, 2019	

THE JOHN CARROLL SCHOOL

703 E. Churchville Road
Bel Air, Maryland 21014
410.838.8333
410.879.2480
Fax: 443.787.4062

New Student and Athletic Physical Form

INSTRUCTIONS: This is the student's confidential medical record only to be shared with Faculty/Staff if pertinent. Must be performed by M.D., D.O., PA, or Nurse Practitioner. PLEASE INCLUDE A PHYSICIAN SIGNED COPY OF IMMUNIZATION RECORDS.

Student Name: _____ DOB: _____ M / F: _____ Yr. of Grad: _____

Student Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected? Y_____ N_____ Hearing: Pass _____ Fail_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
MUSCULOSKELETAL			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE:
□ **Cleared**
□ **Cleared after completing evaluation/rehabilitation for**: _____
□ **NOT cleared for** [Sport(s)]: _____ **Reason**:_____

Recommendation: _____

Name of Physician/Nurse Practitioner/Physician's Assistant: _____**Date**:_____
Address:_____**Phone**:_____

Signature of Physician/Nurse Practitioner/Physician Assistant: _____

I hereby certify that I have reviewed the student pre-participation Health History Questionnaire Form and performed a comprehensive initial pre-participation physical evaluation of the herein named student within the previous 365 days of signature. On the basis of such evaluation and the review of a current History Form, I certify that the student is physically fit to participate in an interscholastic sports program for the current school year. **The date of the student pre-participation History Form and the date of the health care provider's signature above must be after June 1st.**

Physician Stamp:

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Health History Questionnaire Form

GENERAL MEDICAL HISTORY	Y	N
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you currently have an ongoing medical condition? If so, please identify: □ Asthma □ Allergies requiring an Epi Pen □ Diabetes □ Seizures □ Other:		
3. Have you ever had surgery?		
HEART HEALTH ABOUT YOU	**Y**	**N**
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
6. Does your heart race or skip beats during exercise?		
7. Has a doctor ever told you that you have (check all that apply): □ High Blood Pressure □ A heart murmur □ High cholesterol □ A heart infection □ Arrhythmia □ Other:		
8. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)		
9. Do you get lightheaded or feel more short of breath than expected during exercise?		
HEART HEALTH, ABOUT YOUR FAMILY	**Y**	**N**
10. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
11. Does anyone in your family have a heart problem?		
12. Does anyone in your family have a pacemaker or implanted defibrillator?		
13. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?		
BONE AND JOINT QUESTIONS	**Y**	**N**
14. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
15. Have you had any broken or fractured bones or dislocated joints?		
16. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		
17. Have you ever had an x-ray of your neck for atlanto-axial instability? Have you ever been told that you have that disorder or any neck/spine problem?		
18. Have you ever had a stress fracture of a bone?		
19. Do you regularly use a brace or assistive device?		
20. Do you currently have a bone, muscle, or joint injury that bothers you?		
21. Do any of your joints become painful, swollen, feel warm, or look red?		
22. Do you have a history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Y	N
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
24. Do you have asthma or use asthma medicine? (inhaler, nebulizer)		
25. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?		
26. Do you have groin pain or a painful bulge or hernia in the groin area?		
27. Do you have any rashes, pressure sores, or other skin problems?		
28. Have you ever had a herpes or MRSA skin infection?		
29. Do you have headaches with exercise?		
30. Have you ever had a head injury or concussion? If so, date of last injury:		
31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
32. Have you been unable to move your arms or legs after being hit or falling?		
33. When exercising in heat, do you have severe muscle cramps or become ill?		
34. Have you had any other blood disorders?		
35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
36. Do you wear glasses, contact lenses, or hearing aid?		
37. Have you had any problems with your eyes, vision, ears, or hearing?		
38. Do you have an allergy to medicine, food or stinging insects that requires an Epi Pen?		
FEMALES ONLY 39. Do you have a regular menstrual cycle?		
MENTAL HEALTH	**Y**	**N**
40. Are you being treated for or have you ever been treated for? If so, please identify. □ ADHD □ Depression □ Anxiety □ Eating Disorders		
PLEASE LIST ALL CURRENT MEDICATIONS _____ _____		
EXPLAIN YES ANSWERS BELOW #_____ #_____ #_____ #_____ #_____ #_____		

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

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Medical Update and Discretionary Medication Consent Form

This is the student's confidential medical record for the 2019-2020 Academic year.
To be shared with Faculty/Staff if pertinent.

Student Name: _____ Grade: _____

List ALL Medications your student takes on a regular basis: _____

_____

Reason for Medication(s): _____

_____

MEDICAL/HEALTH PROBLEMS: Check all that apply:

___ Severe Allergy

Food_____

Insect_____

Medication_____

Is EpiPen needed? **YES ___ NO ___**

___Diabetes

___Seizure Disorder

___Asthma

Is Rescue Inhaler needed? **YES ___ NO ___**

___ADHD

Is Medication Taken? **YES ___ NO ___**

If so, What Medication _____

___Other_____

MEDICATION ADMINISTRATION:
I give permission for my student to receive medication listed below from the School Nurse. I understand that a generic equivalent may be used.

I would like the following medication(s) made available to my student. (Please Check)

For Upset Stomach:
◯ Chewable Antacid Tablets (Like Tums)

For Mild Allergic Reactions:
◯ Diphenhydramine (Like Benadryl)

For Cough/Sore Throat:
◯ Cough Drops

For Seasonal Allergies:
◯ Loratadine (Like Claritin)

For Headache/Fever/Other Discomfort
◯ Acetaminophen (Like Tylenol) ◯ Ibuprofen (Like Advil)

◯ I do **NOT** want any medication given to my student at school.

PARENT/GUARDIAN INFORMATION:

Mother: _____ (C): _____ (W): _____

Father: _____ (C): _____ (W): _____

Parent/Guardian Email: _____

IF PARENT/GUARDIAN CANNOT BE REACHED ONLY LISTED PERSONS WILL BE CONTACTED AND PERMITTED TO PICK UP STUDENT:

Name: _____ Relationship: _____ (C): _____ (W): _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

THE JOHN CARROLL SCHOOL

Consent, Release, and Assumption of Risk

_____ (print student name) (the "Student"), is a student at The John Carroll School ("JCS").

Consent to Medical Treatment: I/We do hereby authorize JCS employees, nurses, athletic trainers, and coaches to consent to any necessary or advisable medical treatment by any licensed, certified or trained medical professional in the event of any illness or injury to the Student while in school or participating in the Athletic Program, including without limitation, any competition or practice, and while traveling to and from any competition, in the event that I/we cannot be reached after reasonable effort. In addition, if, in the judgment of any representative of JCS, the Student needs immediate care and treatment as a result of any injury or sickness sustained while in school or participating in the Athletic Program, I/we hereby request, authorize, and consent to such care and treatment as may be given to the Student by any licensed, certified or trained medical professional, athletic trainer or any other JCS representative. In either case, I/we do hereby agree to **RELEASE, HOLD HARMLESS and INDEMNIFY** JCS and its directors, officers, employees, and agents from and against any liability, claims, demands, and causes of action arising out of or related to any such treatment. I/We further agree to be fully responsible for any and all expenses incurred in connection with any such treatment, and hereby **RELEASE and DISCHARGE** JCS and its directors, officers, employees and agents from any and all responsibility and liability for such expenses.

Athletic Program: If the Student decides to participate in JCS's athletic program for the **2019-2020** school year (the "Athletic Program"). I/We understand that the Student's participation in the Athletic Program is wholly voluntary. In consideration of the opportunity to participate in the Athletic Program, the receipt and sufficiency of which is hereby acknowledged, I/we consent to the Student's participation in the Athletic Program and agree as follows:

Consent to Disclosure of Educational Records: I/We hereby authorize JCS to release the Student's educational records to the extent the same contain medical information regarding the Student (the "Medical Records") to any health care provider in connection with the furnishing of medical treatment to the Student for any illness or injury sustained while in school or participating in the Athletic Program. I/We understand that this consent shall remain in effect until my/our written revocation is delivered to the Registrar.

Assumption of Risk, Consent and Release of Claims: I/We understand and agree that there are certain dangers, hazards and risks inherent in participating in high school athletic practice and competition, and travel associated therewith, including without limitation, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of the above-named student's body, general health and wellbeing, the effects of any of which could last a lifetime. Because of the dangers of participating in high school athletics, I/we understand that it is the Student's responsibility to adhere to all rules and regulations of his or her sport, and that an infraction of such may result in injury to the Student and/or his or her opponent. I/We also agree not to modify any protective equipment or uniform, and understand that is the Student's responsibility to report faulty or poor-fitting equipment immediately to the coach or Certified Athletic Trainer. I/We further understand and agree that all injuries are to be promptly reported to the Certified Athletic Trainer.

I/We voluntarily and without reservation agree, for myself/ourselves, the Student, and our heirs and personal representatives, to **ASSUME ALL RISK** for any such personal injury, loss of life, or other loss and **RELEASE, HOLD HARMLESS and INDEMNIFY** JCS and its directors, officers, employees, and agents from and against any present or future liability, claims, demands, and causes of action arising out of or related to any personal injury, loss of life, or other loss sustained as a result of the Student's participation in the Athletic Program.

I/We acknowledge that I/we have carefully read, understand, and agree to be bound by the above.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)
Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

2004