THE JOHN CARROLL SCHOOL HEALTH SERVICES
HEALTH FORMS TO BE COMPLETED

ALL forms must be returned to the school nurse in the enclosed envelope by August 1, 2018.

1. **Physical Exam Form:** The enclosed Physical 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. **Immunization Information:** Use attached vaccine form or send a copy from your son/daughter's physician. Vaccine compliance is mandated by law. Therefore, if vaccine records are not submitted by **SEPTEMBER 24, 2018** your son/daughter will not be permitted to attend school.
3. **Health History Questionnaire:** To be completed by parent and student prior to getting a physical exam.
4. **Medical Update/Discretionary Medication Consent:** 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, designated RN, or Certified Athletic Trainer 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.
5. **Medication 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. Policies concerning medications are stated in the Student Handbook at www.johncarroll.org. Please double check that all of the information spaces are completed and mail these records in the enclosed envelope.

If you have any questions, please call Michelle Webster, School Nurse, 410-838-8333 ext. 2010. 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, 2018	
2. Immunization information Use Maryland Department of Health and Mental Hygiene Immunization Certificate	August 1, 2018	
3. Medical Update/Discretionary Medication Consent Form Administration consent form completed and signed by parent	August 1, 2018	
4. Maryland State Department of Education Office of Child Care 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, 2018	

THE JOHN CARROLL SCHOOL HEALTH SERVICES

PHYSICAL FORM 2018-2019

This is the student's confidential medical record only to be shared with Faculty/Staff if pertinent.

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

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

Vision: R 20/_____ L 20/_____ Corrected? Y_____ N_____ Pupils: Equal _____ Unequal_____

MUST BE PERFORMED BY M.D., D.O., PA, or NURSE PRACTIONER
PHYSICALS EXPIRE ONE YEAR FROM THE DATE OF THE CARE PROVIDER'S SIGNATURE
PLEASE INCLUDE A PHYSICIAN SIGNED COPY OF IMMUNIZATION RECORDS

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
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 History 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:

THE JOHN CARROLL SCHOOL HEALTH SERVICES

HEALTH HISTORY QUESTIONNAIRE 2018-2019 (Please complete prior to Physical Exam)

GENERAL MEDICAL HISTORY	Y	N	MEDICAL QUESTIONS	Y	N
1. Has a doctor ever denied or restricted your participation in sports for any reason?			23. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you currently have an ongoing medical condition? If so, please identify: □ Asthma □ Allergies requiring an Epi Pen □ Diabetes □ Seizures □ Other:			24. Do you have asthma or use asthma medicine? (inhaler, nebulizer)		
3. Have you ever had surgery?			25. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?		
HEART HEALTH ABOUT YOU	Y	N	26. Do you have groin pain or a painful bulge or hernia in the groin area?		
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?			27. Do you have any rashes, pressure sores, or other skin problems?		
5. Have you ever had discomfort, pain, or pressure in your chest during exercise?			28. Have you ever had a herpes or MRSA skin infection?		
6. Does your heart race or skip beats during exercise?			29. Do you have headaches with 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:			30. Have you ever had a head injury or concussion? If so, date of last injury:		
8. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)			31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
9. Do you get lightheaded or feel more short of breath than expected during exercise?			32. Have you been unable to move your arms or legs after being hit or falling?		
HEART HEALTH, ABOUT YOUR FAMILY	Y	N	33. When exercising in heat, do you have severe muscle cramps or become ill?		
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)?			34. Have you had any other blood disorders?		
11. Does anyone in your family have a heart problem?			35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
12. Does anyone in your family have a pacemaker or implanted defibrillator?			36. Do you wear glasses, contact lenses, or hearing aid?		
13. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?			37. Have you had any problems with your eyes, vision, ears, or hearing?		
BONE AND JOINT QUESTIONS	Y	N	38. Do you have an allergy to medicine, food or stinging insects that requires an Epi Pen?		
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?			**FEMALES ONLY** 39. Do you have a regular menstrual cycle?		
15. Have you had any broken or fractured bones or dislocated joints?			**MENTAL HEALTH**	Y	N
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?			40. Are you being treated for or have you ever been treated for? If so, please identify. □ ADHD □ Depression □ Anxiety □ Eating Disorders		
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?			**PLEASE LIST ALL CURRENT MEDICATIONS** _____ _____		
18. Have you ever had a stress fracture of a bone?			**EXPLAIN YES ANSWERS BELOW** #_____ #_____ #_____ #_____ #_____ #_____ #_____		
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?					

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

STUDENT SIGNATURE: _____ **DATE:** _____

THE JOHN CARROLL SCHOOL HEALTH SERVICES

MEDICAL UPDATE/DISCRETIONARY MEDICATION CONSENT 2018-2019

This is the student's confidential medical record only to be shared with Faculty/Staff if pertinent.

Student Name: _____ DOB: _____ M/F: _____

Address: _____Home Phone: _____

Advisor: _____ Grade: _____

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

Reason for Medication(s): _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

MEDICAL/HEALTH PROBLEMS: Check all that apply

__ Severe Allergy**	___Bleeding Disorder	___Glasses ___Contacts	___Migraines
Food_____	___Cancer	___Hearing Impairment	___Neurological Concerns
Insect_____	___Cardiac Conditions	___IEP ___504 Plan	___Orthopedic Concern
Medication_____	___Diabetes	___Kidney/Urinary	___Seizure Disorder
__Asthma ___Rescue Inhaler	___Genetic Disorder	___Loss of Vision ___Blind	___Other_____
__ADHD ___Medicated?	___GI Conditions	___Mental Health	

f yes, explain: _____

**If Severe Allergy Noted Above- Student uses: Epi Pen*_____ Benadryl*_____ No Medication_____ Other Medication (severe allergy only) ____

MEDICATION ADMINISTRATION:

I give permission for my student to receive medication listed below on this form as deemed by the Registered Nurse/Licensed Practical Nurse or Certified Athletic Trainer. 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	**For Mild Allergic Reactions:**	**For Cough/Sore Throat:**	**For Seasonal Allergy Symptoms**
◯ Chewable Antacid Tablets (Like Tums)	◯ Diphenhydramine (Like Benadryl)	◯ Cough Drops	◯ Loratadine (Like Claritin)

For Headache/Fever/Other Discomfort

◯ Acetaminophen (like Tylenol) **OR** ◯ Ibuprofen (Like Advil)

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

PARENT/GUARDIAN INFORMATION:

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

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

Parent/Guardian Email: _____

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

Name: _____ Relationship: _____ Ph: _____ Ph: _____

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 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	FLU 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: _____

MARYLAND STATE DEPARTMENT OF EDUCATION OFFICE OF CHILD CARE

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, 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.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects & special Instructions: _____

Medication shall be administered from: _____ to _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

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

Telephone: _____ FAX: _____

Address: _____

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

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

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

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date

THE JOHN CARROLL SCHOOL HEALTH SERVICES

CONSENT, RELEASE, AND ASSUMPTION OF RISK 2018-2019

_____ (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 2018-2019 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.

STUDENT SIGNATURE: _____ **DATE:** _____

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