THE JOHN CARROLL SCHOOL

Health Services

HEALTH FORMS TO BE COMPLETED

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

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.
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, 2019	
2. Immunization information Use Maryland Department of Health and Mental Hygiene Immunization Certificate	August 1, 2019	
3. Medical Update/Discretionary Medication Consent Form Administration consent form completed and signed by parent	August 1, 2019	
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, 2019	

THE JOHN CARROLL SCHOOL

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

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 Practioner. 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 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 History Questionnaire

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:** _____

Medical Update/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? _____

___Diabetes

___Seizure Disorder

___Asthma

___Rescue Inhaler

___ADHD _____Medicated?

___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:** _____