SACRED HEART HIGH SCHOOL

Accredited by Middle States Association of Colleges and Schools

To the Parents or Guardians:

Please return this physical examination report or proof of physical examination received during the school year on registration day. No student will be admitted to Sacred Heart High School without his or her required physical examination and completion of the health history below.

STUDENT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME

HOME ADDRESS	APT#	CITY	STATE	ZIP

HOME TELEPHONE NUMBER	PARENTS CELL NUMBER	DATE OF BIRTH

HEALTH HISTORY *(To be completed by parent.)*

Has the above named student experienced any of the following conditions? If yes, ark (X) and indicate the date.

____ Chickenpox _____
____ Rubella _____
____ Measles _____
____ Mumps _____
____ Whooping _____
____ Cough _____
____ Pneumonia _____
____ Scarlet Fever _____
____ Rheumatic Fever _____
____ Diabetes _____
____ Anemia _____
____ Sickle Cell _____
____ Tuberculosis/(+) PPD_____
____ Epilepsy/Convulsions _____

____ Heart Disease _____
____ Asthma _____
____ Allergies _____
____ Skin Condition _____
____ Sinus, Ear, Nose, Throat Problems _____
____ Kidney/Bladder Problems _____
____ Digestive Problems _____
____ Orthopedic Problems _____
____ Broken Bones _____
____ Vision Problems _____
____ Glasses/Contacts _____
____ Hearing Problems _____
____ Head Injury _____
____ (*Girls Only*) Menstrual Problems _____

Other illnesses are accidents (give dates): _____

Surgeries: _____

Hospitalization (include hospital, dates, reason): _____

Current Medications: _____

Family Doctor/Pediatrician: _____Telephone Number: _____

PLEASE ATTACH IMMUNIZATION RECORD.

34 Convent Avenue • Yonkers, New York 10703 • 914.965.3114 • sacredhearths.org

SACRED HEART HIGH SCHOOL

Accredited by Middle States Association of Colleges and Schools

MEDICATION FORM
2016-2017

STUDENT NAME: _____ GR.: ____
(Please Print)

[ ] My son/daughter does **NOT** have a health condition.

My son/daughter has a health condition that does not require medication. If he/she has any concerns or problems, he/she will report it to the School Nurse.

Health condition(s):

_____

_____

My son/daughter has a health condition that requires him/her to carry medication at all times. He/she is capable of self-medicating when necessary. Extra medication for conditions such as asthma, epilepsy, or diabetes may be kept with the School Nurse. If he/she has any concerns or problems, he/she will report to the School Nurse.

Medication/s my son/daughter currently uses:

_____

_____

_____ _____
Parent/Guardian Signature Phone Number

**The school will not be held responsible for any misuse of medication by the student. No school official may administer medication (including Tylenol or Aspirin) to any student. If there is a serious problem, a school official will call the parent/guardian and 911.*

YONKERS PUBLIC SCHOOLS

Student Health History and Physical Examination

Student's Name: _____ **DOB:** _____ ☐ **M** ☐ **F**

Address: _____ **SCHOOL** _____ **GRADE** ___

Hospitalizations/Surgery: _____

_____

_____

Medications: _____

Ht: _____ **Wt:** _____ **BMI:** _____ **BP:** _____/_____

Vision: R____/____ **L**____/____ **Hearing:** _____ **Scoliosis:** ☐ **Yes** ☐ **No**

Allergies: Foods_____ Meds _____
Other _____ Anaphylaxis _____EPI pen ☐ Yes ☐ No

Asthma: ☐ Active ☐ Inactive ☐ Asthma Action Card® **Diabetes**: ☐ Type 1 ☐ Type 2 ☐ Pump

	WNL	**ABNORMAL: comments**
Skin		
Skeletal		
HEENT		
Neck		
Lung		
Heart		
Abd/ GI		
GU		
Neuro		

Impression: _____
_____

☐ **Full Physical Activity**

☐ **Restricted Physical Activity**

Vaccine	1st	2nd	3rd	4th	5th
DTaP					
Tdap					
OPV/IPV					
MMR					
Hib					
HepB					
HepA					
Varicella					
Meningococcal					
Pneumococcal					
HPV					

PPD:
Date administered:_____
Results: _____ mm
CXR: ____ **Prophylaxis:** ____

☐ **Varicella Disease**:
Date:_____

STAMP

Physician Signature _____ **Date** _____

Address: _____

YONKERS PUBLIC SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the student's parent or guardian:

I request that my child_____ DOB_____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature of Parent/Guardian:_____Date:_____

Address:_____

Telephone: Home:_____Work:_____Cell:_____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student:_____Date of Birth:_____

Diagnosis:_____

Name of Medication:_____

Prescribed Dosage: Frequency and Route of Administration:_____

_____

Time to be taken during school hours:_____

Duration of Treatment:_____

Possible side effects & adverse reactions (if any):_____

_____

Other Recommendations/activity restrictions (e.g. gym):_____

_____

Patient is self-directed and may self-administer medication YES NO

Prescriber's Signature: _____ **Date:**_____

Address:_____ **Telephone #:**_____

Physician Stamp

MEDICATION

Some pupils require daily medication. If possible, they should be given at home (for example, three doses may be given: before school, upon return from school, and at bedtime). However, if medication (pills, liquid, etc.) are necessary during the school day, the following conditions apply:

1. The school must receive a written physician's order with identifying data, the name of the medication, and details about the product and possible side effects along with any activity restrictions. (A form is attached.)

2. A written parent/guardian request (included in the form) must also be submitted. Parent/guardian permission must be renewed each year.

3. The parent/guardian is responsible for delivering the medication to the school in a properly labeled, original container. Medicine will be stored by the School Nurse and/or Assistant Principal and administered as directed.

These conditions apply to all medicine taken in school, even if taken for only one day. Medication found an a student position must be confiscated.

School nurses and other staff may dispense medication, such as aspirin, ONLY WITH A WRITTEN ORDER IN PLACE. Compliance with undocumented requests is contrary to good health practice and is illegal under the the Nurse Practice Act and NY education law.

Student Asthma Action Card

Name: _____D.O.B._____ Grade: _____ Age: _____

Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (H) _____
Address: _____ Ph: (W) _____
_____

Emergency Phone Contact: _____ _____ _____
Name Relationship Phone

Physician Student Sees for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

Peak Flow Monitoring: Personal Best Peak Flow _____

Asthma Severity Level: ☐ **Mild Intermittent** ☐ **Mild Persistent**
☐ **Moderate Persistent** ☐ **Severe Persistent**

Allergies: _____

Daily Medication Plan:

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Special Instructions or Comments:
_____
_____
_____

For Inhaled Medications:

0.5cc Albuterol & normal saline via nebulizer or 2 puffs Albuterol inhaler.

1 amp 0.63mg Xopenex unit dose via nebulizer or 2 puffs Xopenex inhaler.

_____ (other medication)

Is allowed to carry inhaler medication and use that medication by him/herself.

_____ _____
Physician's Signature **Date**

_____ _____
Parent's Signature **Date**

YONKERS PUBLIC SCHOOLS

Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____

ALLERGY TO:_____

Asthmatic _Yes* _No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)
If a food allergen has been ingested, but *no symptoms*:		_ Epinephrine _ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	_ Epinephrine _ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	_ Epinephrine _ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	_ Epinephrine _ Antihistamine
Throat†	Tightening of throat, hoarseness, hacking cough	_ Epinephrine _ Antihistamine
Lung†	Shortness of breath, repetitive coughing, wheezing	_ Epinephrine _ Antihistamine
Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	_ Epinephrine _ Antihistamine
Other†	_____	_ Epinephrine _ Antihistamine
If reaction is progressing (several of the above areas affected), give		_ Epinephrine _ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. **Call 911** (or Rescue Squad: _____) . **State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. Dr. _____ at _____
3. **Emergency contacts:**

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)