



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.

<input type="checkbox"/> Chickenpox _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Rubella _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Measles _____	<input type="checkbox"/> Allergies _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Skin Condition _____
<input type="checkbox"/> Whooping _____	<input type="checkbox"/> Sinus, Ear, Nose, Throat Problems _____
<input type="checkbox"/> Cough _____	<input type="checkbox"/> Kidney/Bladder Problems _____
<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Digestive Problems _____
<input type="checkbox"/> Scarlet Fever _____	<input type="checkbox"/> Orthopedic Problems _____
<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Broken Bones _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Vision Problems _____
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Glasses/Contacts _____
<input type="checkbox"/> Sickle Cell _____	<input type="checkbox"/> Hearing Problems _____
<input type="checkbox"/> Tuberculosis/(+) PPD _____	<input type="checkbox"/> Head Injury _____
<input type="checkbox"/> Epilepsy/Convulsions _____	<input type="checkbox"/> <i>(Girls Only)</i> 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.



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: _____



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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 on 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.



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MEDICATION FORM

STUDENT NAME: _____
(Please Print)

GR.: _____

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, they will report to the Nurse.

Health condition(s):

My son/daughter has a health condition which requires his/her to carry medication at all times. He/She is capable of self-medicating when necessary. Extra medication for conditions such as asthma, epilepsy, diabetes may be kept with the Nurse. If he/she has any concerns or problems, he/she will report to the 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 parent/guardian and 911.*



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

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
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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
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_____ Parent's Signature	_____ Date
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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 <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat† Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung† Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart† Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other† _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 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)



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STUDENT DENTAL FORM

Student Name (Please Print)

Student Address (Please Print)

The pupil's mouth has been inspected. Provisions for further treatment have been made where indicated.

D.D.S. (Please Print)

D.D.S. (Please Sign)

Address

Date