SAINT MARY'S HIGH SCHOOL

51 Clapham Avenue, Manhasset, NY 11030

SCHOOL PHYSICAL FORM

Entering Grade: 9 10 11 12 (Circle One) ☐ Male ☐ Female

Student's Last Name ____ First ____ Address ____ Phone ( ) ____

Father's Name ____ Business Phone ( ) ____ Mother's Name ____ Business Phone ( ) ____

Does this child have any pre-existing condition(s) (i.e. Asthma, Allergies, Diabetes, Hypertension)? ☐ Yes ☐ No ☐ Other

If yes, please specify: ____________________

Is this child taking any medication including vitamins, prescription and non-prescription drugs? ☐ Yes ☐ No List any and/or all medications:

Allergies:

☐ Life Threatening:		☐ Seasonal:	
☐ Food:		☐ Medication:	
☐ Insect:		☐ Other:	

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not Done Date: ____________________

Height: ________ **Weight:** ________ **Age:** ________ **Birthdate:** ________

Body Mass Index: ________ ________ ________

Weight Status Category (BMI Percentile):

☐ less than 5th ☐ 85th through 94th
☐ 5th through 49th ☐ 95th through 98th
☐ 50th through 84th ☐ 99th and higher

Vision	Right Eye	Left Eye
W/O Glasses/Contacts		
With Glasses/Contacts		
Near Point		
Hearing	**Right Ear**	**Lest Ear**
Pass 20 Ds Sc		

Blood Pressure ________
Heart Rate ________
Hernia ________
Lungs ________

Lymph Nodes ________
Thyroid ________
Orthopedic: Scoliosis
____

Urinalysis: Alb ________ **Sugar:** ________

Other: ____________________

Do you approve this student for Interscholastic sports? ☐ Yes ☐ No

If no, please explain on reverse side

Physician's Signature ____________________ Date of Exam ____________________

Affix Physician's Office Stamp

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PARENT & PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To Be Completed by the Parent/Guardian:

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

____
Signature of Parent/Guardian

B. To be competed by the Licensed Health Care Prescriber:

I request that my patient, as listed below, receive the following medication when necessary at school:

Name of Student: ____ Date of Birth: _____________________

1. Diagnosis: ____ICD-9 code______________________

   Medication: __________________________________Dosage: _____________________________

   Route: _______________________________________Frequency: ___________________________

   Possible side effects: ____

2. Diagnosis: ____ICD-9 code______________________

   Medication: __________________________________Dosage: _____________________________

   Route: _______________________________________Frequency: ___________________________

   Possible side effects: ____

3. Diagnosis: ____ICD-9 code______________________

   Medication: __________________________________Dosage: _____________________________

   Route: _______________________________________Frequency: ___________________________

   Possible side effects: ____

____
Name of Licensed Prescriber **(please print)** **Title**

____
Prescriber's Signature **Date**

____(____)______________________________
Address **Telephone Number**

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AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

Directions for the Health Care Provider: An attestation is needed for a student to independently carry and use their medication as requires by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student's Name: ____ DOB: ____________

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery devise if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and required Insulin/Glucagon/Diabetes Supplies
- ☐ ______________________ which requires rapid administration of ____________________
  (Other Diagnosis) (Medication Name)

Physician's Signature: ____ Date: ___________

I request that my child, ____ be permitted to carry the above prescribed medication(s) on his/her person, locker, or PE locker. The student has been instructed in and understands the purpose, appropriate method frequency and use of the medication(s). The student understands that they are responsible and accountable for carrying and using their medication(s). as I consider him/hr responsible this medication may be used independently at any school/school sponsored activity with no supervision by school staff.

____ _______________________
Parent/Guardian Signature Date

____ _______________________
Student's Signature Date

The licensed prescriber's statement and parent request are accepted. The student will be permitted to carry and use the prescribed medication(s). The parent/guardian will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

____ _______________________
School Nurse's Signature Date

For Office Use Only

Date form received in health office: ____

Comments: ____