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 completed 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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SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION

Directions for the Health Care Provider: An attestation is needed for a student to independently carry and use their medication as required by NYS law. A **provider's 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.** **The nurse is available on school grounds from 7:45 a.m.- 2:45 p.m. The nurse needs to be made aware of medication use and response.**

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 device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

- ☐ Allergy and requires Epinephrine Auto-Injector
- ☐ Asthma or Respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies

This requires rapid administration of ___________________________________

(Name of Medication)

Physician's Signature: ____ Date: ___________________

Parent's / Guardian's Permission for Independent Use and Carry

I request that my child, ____ be permitted to carry the above prescribed medication(s) on his/her person, locker, or PE locker.** **Parents need to speak to the faculty in charge of clubs, drama, field trips and after-school activities regarding their child's medication as nurses are not available.** 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). I agree that my child can use his/her medication effectively and may carry and use this medication independently at any school/school sponsored activity.

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 parents/guardian will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

School Nurse's Signature: ____ Date: _____________

Parent and M.D. (physician) must fill in and sign both medication sheets.