Saint Thomas' Episcopal School Certificate of Participation - Medical Record

TO BE COMPLETED BY THE PARENT

Please complete both sides of this form

Student's Last Name **First Name** **FALL Grade Level**

Address ______________________________

Birthdate __________ **Male / Female** ____ **Home Phone** __________

Student's Social Security Number # ______________________

Allergies? Y ☐ N ☐ (If yes,list) **AllergyTreatment**

______________ ______________________

______________ ______________________

______________ ______________________

Special needs, prior hospitalizations or surgeries? Y ☐ N ☐

(If yes, make notes on back)

Medications now taken daily ______________________

Mother's Name: ______________________

Father's Name: ______________________

We may be reached at the following business phone numbers:

Father's ______________ **Mother's** ______________

Cell Phone / Pager ______________ **Cell Phone / Pager** ______________

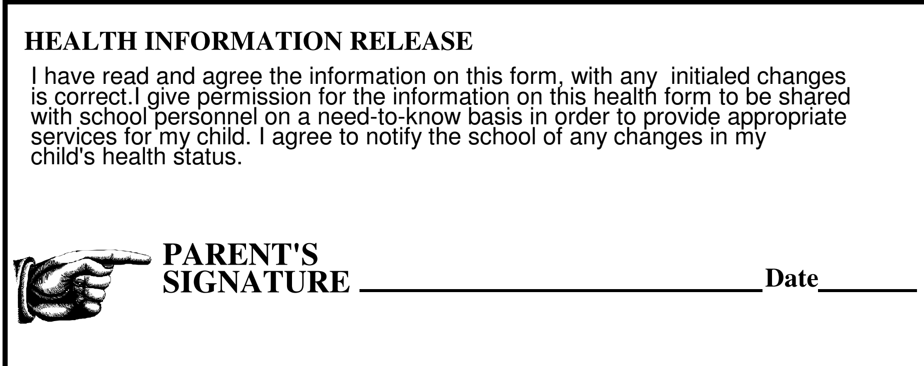
E-Mail address 1: ______________________

E-Mail address 2: ______________________

Person(s) to call if the parents are not available:

Name ______________________ **Phone #** __________

Name ______________________ **Phone #** __________



HEALTH INFORMATION RELEASE

I have read and agree the information on this form, with any initialed changes is correct.I give permission for the information on this health form to be shared with school personnel on a need-to-know basis in order to provide appropriate services for my child. I agree to notify the school of any changes in my child's health status.

PARENT'S SIGNATURE ______________________ **Date**________

TO BE COMPLETED BY A PHYSICIAN

Vaccines	Date	Date	Date	Date	Date
DTP, DT, Td					
Tdap					
POLIO VAC.					
MEASLES					
MUMPS					
RUBELLA					
HIB					
HEP B					
VARICELLA					
TB SKIN TEST*					
HEP A					
PNEUMOCCOCAL					
MENINGOCOCCAL					

* Not Required

Height: ______ in. **Weight:** ______ # **BP:** ______

Limitations in physical activity: ______________________

Other considerations: ______________________

<<< VISUAL SCREENING >>>

Distant Acuity Right Eye ____________ Left Eye ____________

Results of Visual Screening: Passed ____ Referred ____ Glasses ____ Contacts ____

SCREENER: X ______________________ **Date** __________

<<< HEARING SCREENING >>>

	500	1000	2000	4000
Right Ear	____	____	____	____
Left Ear	____	____	____	____

Results of Hearing Screening: Passed ____ Referred ____ Hearing Aid ____

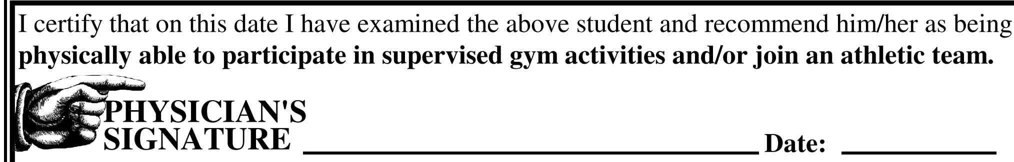
SCREENER: X ______________________ **Date** __________

<<< SCOLIOSIS >>>

REQUIRED OF STUDENTS ENTERING GRADES 6 & 9

Spinal Screening: Passed _____ Observation _____ Referred_____

I certify that on this date I have examined the above student and recommend him/her as being **physically able to participate in supervised gym activities and/or join an athletic team.**



PHYSICIAN'S SIGNATURE ______________________ **Date:** __________

Please return this completed form to Saint Thomas' Episcopal School before August 4.

TO BE COMPLETED BY THE PARENT

Student's Name ________________________________ Fall Grade ________

1. Have you ever passed out during or after exercise? Yes ☐ No ☐
2. Have you ever been dizzy during or after exercise? Yes ☐ No ☐
3. Have you ever had chest pain during or after exercise? Yes ☐ No ☐
4. Have you ever been told you have a heart murmur? Yes ☐ No ☐
5. Has any family member died of heart problems or unexpectedly befor the age of 50? Yes ☐ No ☐
6. Have you ever had a head injury, been knocked unconscious, or had a concussion? Yes ☐ No ☐
   If yes, please explain____
7. Have you ever had a seizure? Yes ☐ No ☐
8. Do you have frequent or severe headaches? Yes ☐ No ☐
9. Have you ever gotten unexpectedly short of breath during exercise? Yes ☐ No ☐
10. Do you cough, wheeze or have trouble breathing during or after exercise? Yes ☐ No ☐
11. Do you have asthma? Yes ☐ No ☐
    If yes, please submit an Asthma Action Plan to the School Nurse.
12. Have you ever become ill from exercise in the heat? Yes ☐ No ☐
13. Have you ever broken a bone? Yes ☐ No ☐
    If yes, please explain____
14. Have you ever had neck or back problems? Yes ☐ No ☐
    If yes, please explain____
15. Have you ever had knee or ankle injuries or problems? Yes ☐ No ☐
    If yes, please explain____
16. Is there any further information we may need to know about your child? Yes ☐ No ☐
    If yes, please explain____

PARENT'S SIGNATURE ______________________________ Date: ________________