Pocantico Hills Central School Health Services

INTERVAL HEALTH HISTORY REVIEW FORM FOR SPORTS PARTICIPATION

Your parent /guardian needs to complete EVERY question on this form EACH season and sign it and date it at the bottom. For acceptance, it CANNOT be completed more than 30 days prior to the start of tryout sessions or first practice of the sport you are interested in playing. The nurse's office must have a record of a recent physical exam. (Valid for a period of 12 months through the last day of the month in which the physical was performed).

To Be Completed By Parent/Guardian

MUST BE PRESENTED IN PERSON BY STUDENT TO OBTAIN SPORTS CLEARANCE

Student: ______________________________ Grade: ______ Sport: _______________

Date of Last Physical: ______/______/______

Part A: To Be Completed By The Parent Or Guardian

Note: "Yes to any of these questions does not mean automatic disqualification from the athletic activity indicated above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts.

HAS YOUR CHILD EVER:		
Had a severe allergic reaction to medications, insect stings or food?	☐ Yes	☐ No
Been prescribed an Epipen✳?	☐ Yes	☐ No
Had asthma or reactive airway disease?	☐ Yes	☐ No
Been prescribed an inhaler✳?	☐ Yes	☐ No
Had any fainting, dizziness or fatigue especially during or after exercise?	☐ Yes	☐ No
Had a concussion?	☐ Yes	☐ No
Had a seizure?	☐ Yes	☐ No
Had heart problems, murmurs, extra beats or high blood pressure?	☐ Yes	☐ No
Had any illnesses or injuries lasting more than five days?	☐ Yes	☐ No
Had frequent or prolonged absences (more than 5 consecutive days) from school due to illness or injury?	☐ Yes	☐ No
Had any hospitalizations or surgery?	☐ Yes	☐ No
Had any injury or fracture to any body part?	☐ Yes	☐ No
Had loss of vision in one eye or been diagnosed with a single organ (i.e. kidney, testicle)	☐ Yes	☐ No
Developed any chronic disease? (i.e. diabetes, bleeding disorder)	☐ Yes	☐ No
Had any condition that may be exacerbated by playing sports?	☐ Yes	☐ No

IS YOUR CHILD PRESENTLY:		
Wearing glasses or contact lenses?	☐ Yes	☐ No
Taking any medication or under a physician's care at this time?	☐ Yes	☐ No
Wearing an orthodontic appliance?	☐ Yes	☐ No

OVER

Pocantico Hills Central School Health Services

PART B: TO BE COMPLETED BY PARENT OR GUARDIAN

If yes to any of the answers in PART A, please explain:

____
____
____
____
____
____
____

Additional medical clearance may be necessary from your private medical doctor. * If your child uses an inhaler or has an Epipen, medication orders MUST be on file in the Nurse's Office. See your school nurse.

PART C: PARENTAL PERMISSION:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT:
I clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in this form. The responses to the questions in Part A are accurate to the best of my knowledge. If there is any change in my child's health status, I will inform the school nurse of the revised situation as soon as possible.

I am aware that Pocantico Hills CSD has a concussion policy and the guidelines for such are available on the Web site under athletics and the nurse's web pages at www.pocanticohills.org. I have read the Concussion Awareness information and I acknowledge that there is a potential for injury with participation in any sport. I understand that even with the best coaching, the most advanced protective equipment and strict observance of rules, serious/severe injuries are still a possibility. I understand the risks and all the responsibilities of my child while participating in the Pocantico Hills Interscholastic Athletics Program.

My child has my permission to participate.

PARENT/GUARDIAN SIGNATURE ______________________________ DATE _____/______/_____

POCANTICO HILLS CENTRAL SCHOOL

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name: DOB: Gender: ☐ M ☐F

School: Grade: ☐NA Exam Date:

HEALTH HISTORY

Specify Current Diseases

☐Asthma (☐Intermittent or ☐Persistent)

Quick relief inhaler: ☐Yes ☐No

Asthma Action Plan: ☐Yes ☐No

☐Type 1 Diabetes ☐Type 2 Diabetes

☐Hyperlipidemia ☐Hypertension

☐Other:

Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date:
PPD:	☐Positive	☐Negative	☐Not Done	Date:
Elevated Lead:	☐Yes	☐No	☐Not Done	Date:
Dental Referral:	☐Yes	☐No	☐Not Done	Date:

☐ Allergies - See page 2 for details.

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _______

Angle of trunk rotation via scoliometer: __________

Body Mass Index:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th- 94th

☐ 5th- 49th ☐ 95th- 98th

☐ 50th-84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐Pass	☐Fail	

Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner:☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached

Specify any abnormalities:

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)

☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,

☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,

☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking

☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:

☐ Medical/prosthetic device:

☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

*Self Directed: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

**Self Admin/Self-Carry: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: Date: Phone: ( )

ALLERGIES

☐ None ☐ Non Life-Threatening ☐ Life-Threatening

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ☐History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐ Immunizations received today:

☐ Will return on: to receive:

Provider / Parental Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: Date:

Provider Name: (please print) Phone #:

Provider Address: Fax #:

Parent/Guardian Signature: ______________________________ Date:

Medical Provider Email:

Return to:

School Nurse: Gay Harmon RN School:

Phone #: (914) 631-2440, ex 113 Fax: (914) 631-2441 Date:

Permission to Administer Multiple Medications

Student Name: ______________________________________ DOB: ____________________
Grade: ________ Teacher/HR: ___________________________ School: __________________

To Be Completed By Health Care Provider

Diagnoses ____

Medication Name	Dose	Route	Time	☑ applicable boxes below
				☐ AM ______ ☐ Bus ☐ FT ☐ SSA ☐Self-Directed ☐ Self Admin-Self Carry
				☐ AM ______ ☐ Bus ☐ FT ☐ SSA ☐Self-Directed ☐ Self Admin-Self Carry
				☐ AM ______ ☐ Bus ☐ FT ☐ SSA ☐Self-Directed ☐ Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

Code	Description
AM	Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
Bus	Medication must be available on bus
FT	Medication is needed on field trips
SSA	Medication is needed school sponsored extra-curricular activities
Self-Directed	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.
Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please Print) ______________________________

Prescriber's Signature ________________________ **Date** __________ **Phone** ______________

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature ________________________ **Date** __________ **Phone** ______________

Self-Administer/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature ________________________ **Date** __________ **Phone** ______________

School Nurse: Gay Harmon RN

Phone: 914-631-2440, ext. 113 Fax: 914-631-2441 Email: gharmon@pocanticohills.org