MARYVALE

Student's Full Name _____ Grade _____

Dear Parent/Guardian,

Please carefully read and **have your physician complete the forms** according to explained requirements. As the Parent/Guardian, it is your responsibility to verify that all information is completed and returned to the Health Suite in a timely manner.

The deadline for returning forms is August 1, 2018. No student may attend classes, tryouts, rehearsals or practices until forms have been received and reviewed by the School Nurse. This policy will be enforced by Administration.

Physical exams are required for **ALL STUDENTS ANNUALLY. Physical examinations must be completed between March 1, 2018 – July 15, 2018 and received in the nurse's office by August 1, 2018.**

Record of Immunization: Maryland Immunization Certification Form (DHMH896) must be up-to-date and received in the Health Suite by **August 1, 2018**. The State of Maryland requires up-to-date immunization records on file for a student to attend school.

All information is confidential. If your daughter is under a physician's care or taking medication on a regular basis, please include that information on the form.

Consent for Prescription Medications (Epi Pens, antibiotics, inhalers, etc.) that may need to be given during the school day must be accompanied by a written and signed order from the prescribing physician and be in the original container (your pharmacist will give you a second labeled container for school use if you request it). To avoid an unexpected medication reaction at school, please administer the first dose of a new prescription or OTC medication at home, except for "as needed" (PRN) emergency medication. If your daughter is required to carry an inhaler or Epi Pen (with signature permitting such from an authorized prescriber) it is strongly recommended that an extra inhaler or Epi Pen be stored in the Health Suite for emergency use. An Allergy Action Plan, completed annually by the health care provider, is required for students with Epi Pens. Information regarding this form is located on the Maryvale website or by contacting the School Nurse. Medications may NOT be kept in student lockers or backpacks. **Unused medication must be picked up by a parent at the end of the school year or it will be discarded.**

Under the advisement of Baltimore County Department of Health/School Nurses and in compliance with the Nurse Practice Act, NO medication will be dispensed without the written consent of the parent and physician.

Your cooperation is appreciated. Please call if you have any questions regarding any aspect of these policies. They are designed with the best interest of your daughter in mind. Questions may be directed to the Health Suite by calling **(410) 308-8533** or emailing nurse@maryvale.com. We look forward to a happy and healthy year for all.

Sincerely,

Kelly Bonsack, RN
Diane Richard, RN
Dr. Teri McCambridge, Medical Director

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

MARYVALE

Consent for Prescription Medications

(Order to be written by physician)

Please note one form must be completed annually for each medication. Medications should be brought to school in the original labeled container.

Student's Full Name: _____

Medication (dosage/ route/ time/ frequency): _____

If PRN, for what symptoms: _____ Stop date: _____

Relevant side effects: _____

Asthma Inhaler/ Epi-Pen/ Insulin:

☐ Student is able to self-administer and carry asthma inhalant medication as prescribed above. She has been instructed by her physician, nurse, parent **(circle at least one**) and understands the purpose and appropriate methods and frequency of use of her inhaler.

☐ Student is able to self-administer and carry epinephrine auto-injector as prescribed above. She has been instructed by her physician, nurse, parent (**circle at least one**) and understands the purpose and appropriate methods and time to administer the auto-injector. *

☐ Student is able to self-administer her insulin with supervision in the nurse's office and/or manage her insulin pump as she has been trained by her physician, nurse, parent (**circle at least one**). **

***Please attach Allergy Action Plan if epinephrine auto-injector is prescribed.**

****Please attach diabetes school orders as applicable.**

Parent/ Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Name printed: _____

Physician Telephone Number: _____

MARYVALE

Allergy Action Plan

Place Your Daughter's Picture Here

Student's name: _____ **DOB:** _____

Allergy to: _____ **Asthmatic:** **Yes** _____ **No** _____

Step 1: Treatment

Symptoms		Give checked medication(s)	
• If a food allergen has been ingested, but no symptoms:		☐ EpiPen	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of face or extremities	☐ EpiPen	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
• Throat *	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
• Lung *	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
• Heart *	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
• Other * _____		☐ EpiPen	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. **** Potentially life threatening***

Dosage

Epinephrine: inject intramuscularly (circle one): EpiPen EpiPen Jr.

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 a parent/ guardian cannot be reached, so not hesitate to medicate or take child to medical facility!

Parent/ Guardian signature _____ **Date** _____

Doctor's signature (required) _____ **Date** _____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____ Date of Birth _____

Parent/Guardian _____ Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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