GWA Mandatory Medical Form

Parents/guardians please complete:

Student's Name:

First ______________________________ Last ____

Date of birth: _______________________

Does your child have any existing health conditions *(diabetes, asthma, allergies)***? If 'yes' please list below:**

____

____

____

____

Please list all daily medications and/or emergency medications your child uses *(asthma inhaler, epi-pen, etc.)***:**

____

____

____

____

Please Note: *In compliance with our GWA Medication Administration Policy, all medications are required to be provided by the parents with a doctor's prescription. This includes all symptomatic medications such as doliprane or cough medicine.*

Does your child have any allergies *(medications, environmental or dietary)***? Please list below:**

____

____

____

____

Please Note: *If your child has allergies, your child's physician* ***must*** *complete the required Allergy Plan included on pages 6-8.*

Required Vaccinations

Please enter the date each vaccine was administered (MM/DD/YYYY):

Diptheria/Tetanus/Pertussis/Poliomyelitis/Hib

1 ______ 2 ______ 3 ______ 4 ______

Tetanus/Diptheria/Pertussis Booster *(usually at 11-12 years of age)*

1 ______

Measles/Mumps/Rubella

1 ______ 2 ______ 3 ______

BCG (Tuberculosis)

1 ______

Please Note: *All required vaccines are MANDATORY before entry to GWA. All medical and religious exemptions must be provided by a physician with a completed Vaccination Exemption Form.*

If your son/daughter has NOT received a BCG vaccine we require one of the following within the past year prior to initial entry to GWA:

- *Tuberculin Skin Test (TST)/PPD test*
- *Quantiferon blood test OR*
- *Chest x-ray*

Please provide a copy of the above test result to the GWA Health Services staff.

Optional Vaccinations

Please enter the date each vaccine was administered (MM/DD/YYYY):

Hepatitis A

1 ______ 2 ______

Hepatitis B *(strongly recommended)*

1 ______ 2 ______ 3 ______

Influenza *(strongly recommended, especially for students with asthma and other chronic medical conditions)*

1 ______ 2 ______ 3 ______

Meningococcal Meningitis

1 ______ 2 ______

Pneumococcal Conjugate *(strongly recommended)*

1 ______ 2 ______ 3 ______ 4 ______

Varicella *(strongly recommended)*

1 ______ 2 ______

If chickenpox was diagnosed by a physician, please note the date: ______________________

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for the medical staff at GWA to treat my son/daughter to the best of their ability and the exchange of medical information from healthcare providers if necessary.

Signature of parent/guardian: ______________________________ Date: ____________

Health History

To be completed by your child's physician:

Condition	Yes	No	Comments
Previous surgeries			
Allergies (food/drugs/insects/ seasonal) ***If "Yes," completion of allergy plan required***			
Respiratory issues (ex. Asthma)			
Attention (ADHD), developmental, behavior disorder (ex. Autism)			
Bladder or bowel problems			
Cerebral palsy or other muscular development issues			
Diabetes ***If "Yes," completion of a diabetic management plan required***			
Vision problems - Do they require glasses?			
Hearing problems			
Cardiac/heart condition			
History of head injuries/ concussions? Frequent headaches or migraines?			
Spinal injuries or scoliosis			
History of broken bones			
Neurologic disorders (seizures)			
Anxiety/depression or other psychosocial concerns			
History of fainting			

Additional Comments:

Physical Assessment

To be completed by your child's physician:

Assessment	Normal	Abnormal	Abnormal findings/recommendations:
Hair/Scalp			
Skin			
Eye/vision			
Ears/hearing			
Nose and throat			
Teeth and gingiva			
Lymph glands			
Heart/cardiovascular			
Lungs/respiratory			
Abdomen			
Genitourinary			
Neuromuscular			
Extremities			
Spine (scoliosis)			
Other			

Additional Comments:

Height (cm):	Pulse:
Weight (kg):	Blood Pressure:

By signing or stamping below; I confirm that this child is in good medical health and is able to participate in school sports, after school physical activities and physical education class.

Signature of Physician:

____ Date: ____________________

Physician Name (printed): ____

Physician Contact Information (address, phone): ____

____

____

____

Mandatory Allergy Management Plan

To be completed by the physician if the student has allergies:

ALLERGY (including food and medications)	**SEVERITY OF REACTION** (severe*, moderate,mild)

***If a student has a SEVERE reaction, they will not be able to eat food provided by the GWA school cafeteria.**

Signs of a systemic allergic reaction	(Circle all that apply for this student):
Respiratory	shortness of breath, repetitive coughing, wheezing
Cardiac	weak pulse, fainting, dizziness
Oral/ENT	itching/swelling of lips, tongue or mouth
Skin	hives, itchy rash, swelling of face or extremities
Abdominal	nausea, abdominal cramping, vomiting

Action for Minor Allergic Reaction

If symptoms include:

____

____

____

Give ____(Name of medication)

__________________________ (dose) ___________________________ (route)

Call ____________________________________ (parent guardian name and number)

or ____________________________________ (emergency contact name and number)

If condition does not improve within _____ minutes, follow steps for Major Reaction below.

Action for Major Allergic Reaction

If ingestion is suspected and/or symptoms are:

____

____

____

Immediately Give ____(Name of medication)
_____________________________ (dose) _________________________________ (route)

Call for ambulance immediately.

☐ Repeat epinephrine (adrenaline) ______ mg IM if no change/improvement in symptoms after _______ minutes of first administration of epinephrine.

Call ____ (parent guardian name and number)
or ____ (emergency contact name and number)

Required Signatures:

Physician's name (print):____

Physician signature: ____

Parent's name (print): ____

Parent's signature: ____

Allergy Individualized Care Plan

To be completed by Parent/Guardian:

If student has a food allergy, please choose one of the following in regards to the food service at GWA:

☐ **Plan A**: Regular Lunch Plan with no special accommodations (menu can be viewed online and a lunch sent if there is something to be avoided on the menu)

☐ **Plan B**: Modified Lunch Plan (for mild to moderate food allergies/intolerances or other special diet needs). Please specify the food groups to be eliminated from your child's meal tray:

A. ____

B. ____

C. ____

D. ____

For example; if 'dairy' is documented as a moderate food intolerance by a physician, cafeteria staff would then remove all foods that may contain dairy including baked goods, sauces, and other items that may be contaminated with dairy.

☐ **Plan C**: Non GWA Cafeteria Plan. Family is fully responsible for preparing all food and snacks for their student.

Classroom Expectations:

If your child has a food allergy from Nursery to Grade 3, administration and the school nurse can help provide the following. Please indicate what actions you would like to take:

☐ A separate, personal space for the student to eat lunch and snacks.

☐ Communication to all parents in the same class regarding your child's allergy, while respecting privacy, detailing your needs as to whether class-wide treats may be brought in during the year, etc.

☐ A no SHARE, no TRADE zone for all food and snacks in your student's class.

Field Trips:

If your child (in Lower School) participates in any field trips away from the GWA campus during the school year, we ask that you communicate clearly with the teacher(s) and GWA staff that will be accompanying your son or daughter as soon as possible, regarding their dietary needs. If a student has a chronic medical condition, the school nurse will coordinate with the parent(s) and teachers regarding appropriate medical care/treatment during the field trip.