St. Thomas' Episcopal School Certificate of Participation / Health Record

Student Name | Fall Grade | Birthdate | Gender ❑F ❑M

Allergic to: .....

Medications now taken daily: .....

Street Address, City, State, Zip: .....

Parent 1 Name ..... Mobile Phone ..... Home Phone ..... Business Phone .....

Parent 2 Name ..... Mobile Phone ..... Home Phone ..... Business Phone .....

Parent 3 Name ..... Mobile Phone ..... Home Phone ..... Business Phone .....

PERSONS TO BE CONTACTED IF PARENTS ARE NOT AVAILABLE:

Name: ..... Phone: ..... Name: ..... Phone: .....

HEALTH INFORMATION RELEASE

I have read this form and agree that the information contained herein, with any initialed changes, is correct. I give permission for the information on this Certificate of Participation / Health Record 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 .....

THIS PORTION TO BE COMPLETED BY HEALTH CARE PROVIDER

Height: ..... Weight: ..... Blood Pressure: .....

Are there any health problems of which the school should be aware? If so, please explain:

.....

.....

.....

Are there any limitations on physical activity? If so, please explain:

.....

.....

.....

I certify that 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.

Health Care Provider's Signature ..... Date .....

VISUAL SCREENING

Distant Acuity	Right Eye	20/	Left Eye	20/
Results of Visual Screening	❑ Passed ❑ Referred ❑ Failed ❑ With Correction			

HEARING SCREENING

	1000	2000	4000
Right Ear			
Left Ear			
Results of Hearing Screening	❑ Passed ❑ Referred ❑ Failed		

SCOLIOSIS

required of students entering grades 5, 7, and 8

Results of Spinal Screening	❑ Passed ❑ Observation ❑ Referred

Please complete BOTH sides of this form and return completed form to St. Thomas' Episcopal School before August 1

St. Thomas' Episcopal School Certificate of Participation / Health Record

Student Name	Fall Grade	Birthdate	Gender ❑F ❑M

TO BE COMPLETED BY THE PARENT

1. Has your child ever passed out during or after exercise? Yes ❑ No ❑
2. Has your child ever been dizzy during or after exercise? Yes ❑ No ❑
3. Has your child ever had chest pain during or after exercise? Yes ❑ No ❑
4. Has your child ever been told that he or she has a heart murmur? Yes ❑ No ❑
5. Has any family member died of heart problems or unexpectedly before the age of 50? Yes ❑ No ❑
6. Has your child ever had a head injury, been knocked unconscious, or had a concussion? Yes ❑ No ❑
   If yes, please explain: .....
7. Has your child ever had a seizure? Yes ❑ No ❑
8. Does your child have frequent or severe headaches? Yes ❑ No ❑
9. Has your child ever gotten unexpectedly short of breath during exercise? Yes ❑ No ❑
10. Does your child cough, wheeze, or have trouble breathing during or after exercise? Yes ❑ No ❑
11. Does your child have asthma? Yes ❑ No ❑
    If yes, please submit an Asthma Action Plan to the School Nurse Yes ❑ No ❑
12. Has your child ever become ill from exercise in the heat? Yes ❑ No ❑
13. Has your child ever broken a bone? Yes ❑ No ❑
    If yes, please explain: .....
14. Has your child ever had neck or back problems? Yes ❑ No ❑
    If yes, please explain: .....
15. Has your child ever had knee or ankle 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