

This form is due by the first day of school.

MEDICAL EXAMINER'S STATEMENT ON HEALTH AND ACTIVITY STATUS

Student's Name _____ Date of Birth _____
 Last First Middle
 School _____ Grade (Circle) 9 10 11 12

DATE OF EXAMINATION: _____

NOTE: Date of examination indicates beginning of 12-month eligibility for competitive athletics.



IMMUNIZATIONS (Give month and year)

Polio					
DTP/DTaP					
MMR				Td	Tdap
Hep B					
Hep A			Varicella		
HPV				MCV	

HT _____ WT _____ Blood Pressure _____
 Visual acuity: without correction R _____ L _____
 with correction R _____ L _____
 Hearing loss: No _____ Yes _____

Date of last TB test _____
 Result of test _____
 History of BCG? _____
 Follow-up indicated _____
 Date and result of chest x-ray _____

(If there is a hearing loss, please complete audiogram.)		<u>500</u>	<u>1000</u>	<u>2000</u>	<u>3000</u>	<u>4000</u>	<u>6000</u>
	R	_____	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____	_____

COMMENTS: _____

Please answer the following questions:

1. Is there a defect of vision, hearing, or speech for which the school should compensate by proper seating or other actions? [] Yes [] No
If yes, please specify _____
2. Are there previous operations, injuries, or illnesses of which the school should be aware? [] Yes [] No
If yes, please specify _____
3. Is there a physical defect which limits participation in: Classroom activities? [] Yes [] No
Physical Education? [] Yes [] No
Competitive athletics. [] Yes [] No
If yes, please specify limitation and recommendation for alternative activity _____
4. Is this student subject to a condition which may result in a classroom emergency (Epilepsy, fainting, diabetes, severe asthma, allergy, hypersensitivity to bee or other insect venom?) [] Yes [] No
If yes, please specify _____
5. Is there an emotional mental or physical condition for which this student should remain under periodic medical observation? [] Yes [] No
If yes, please specify _____
6. Is this student currently (or routinely) on medication? [] Yes [] No
If yes, name of medication and dosage _____

7. Please complete the Authorization for Medication(s) During School Hours (on reverse side) for ANY medication the student may require during the school day.

Not Valid Unless Signed, Stamped & Dated

Signature of Physician or Health Care Provider Name:
PLEASE STAMP/AFFIX NAME, ADDRESS, AND CONTACT INFORMATION OF PHYSICIAN/HEALTH CARE PROVIDER Address:
 Phone:

**San Mateo Union High School District
Authorization for Medication(s) to be Taken During School Hours**

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.

With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT: School Name _____

Student Name _____
Last First Gender Date of Birth _____

Physician/Health Care Provider's Name Address Telephone _____

In regards to the medication authorized below by her/his physician/health care provider:

I request that my student be assisted in taking the medicine(s) at school by authorized persons: Yes _____ No _____

I request that my student be permitted to carry medication & self-medicate her/himself: Yes _____ No _____

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

Date Signature of Parent/Guardian Home Phone Emergency _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medication: _____

Form: _____ Dose & route: _____

If medicine is to be given DAILY, at what time(s): _____

If medicine is to be given WHEN NEEDED, describe indications: _____

How soon can it be repeated?: _____

List significant side effects of medication: _____

Length of time this treatment is recommended: _____

In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes _____ No _____

Date: _____ Signature of Authorized Health Care Provider: _____

Health Care Provider Address Stamp (required):