This form is due by the first day of school.

**SAN MATEO UNION HIGH SCHOOL DISTRICT**

## 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.**

DATE HERE

HT _____ WT _____ Blood Pressure _____

Visual acuity: without correction R_____ L _____

with correction R_____ L _____

Hearing loss: No_____ Yes _____

| (If there is a hearing loss, please complete audiogram.) | | 500 | 1000 | 2000 | 3000 | 4000 | 6000 |
|---|---|---|---|---|---|---|---|
| | R | ___ | ___ | ___ | ___ | ___ | ___ |
| | L | ___ | ___ | ___ | ___ | ___ | ___ |

**IMMUNIZATIONS** (Give month and year)

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

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

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 recommendations _____
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:**

**Address:**

**Phone:**

**PLEASE STAMP/AFFIX NAME, ADDRESS, AND CONTACT INFORMATION OF PHYSICIAN/HEALTH CARE PROVIDER**

# 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 _____Gender_____ Date of Birth_____
Last First

_____(_____)_____
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 have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. 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?: _____ Length of time this treatment is recommended: _____

List significant side effects of medication: _____

**In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes_____ No_____**

**If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel: Yes_____ No_____ N/A_____**

**Date:** _____ **Signature of Authorized Health Care Provider:** _____

**Health Care Provider Address Stamp (required):**