



Presbyterian Pan American School

Kingsville, Texas 78363

Health Record

Class Year: _____

Student's Last Name _____ First Names _____ Sex M F

Home Address _____

Date of birth _____ Religion _____ Blood group _____

Health Insurance _____ Group Number _____ Policy Number _____

FATHER'S INFO

Name _____ Phone Number (home) _____

E-mail _____ Phone Number (work) _____

MOTHER'S INFO

Name _____ Phone Number (home) _____

E-mail _____ Phone Number (work) _____

IN CASE OF EMERGENCY IF PARENT CANNOT BE CONTACTED, PLEASE NOTIFY (Name and Relationship):

Phone Number (home) _____ Phone Number (work) _____

Phone Number (Mobile) _____ Fax: _____

ALLERGY INFORMATION

Penicillin No Yes, Reaction _____

Sulfonamides No Yes, Reaction _____

Other drugs No Yes, Which _____
Reaction _____

Foods No Yes, Which _____
Reaction _____

Insects No Yes, Which _____
Reaction _____

Others No Yes, What _____
Reaction _____

Tetanus immunization _____, _____, _____

Presbyterian Pan American School does not assume responsibility for giving needed permission for major medical care. This is the responsibility of the parent or guardian. By my signature below, I hereby authorize the headmaster or his representative to give my permission for necessary immediate medical care, including anesthetics, blood transfusions if necessary, and any in or outpatient procedures or exams ordered by a physician, with the understanding that I will be notified as soon as possible.

_____ Date

_____ Signature of Parent or Guardian

Health Record

Class Year: _____

Student's Name: _____

MEDICAL UPDATE

Please describe your child's past and present health conditions or problems which could be of concern while at Presbyterian Pan American School.

General Health: Excellent Good Fair Poor

Please indicate if your child has had or suffers from any of the following:

Scarlet Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____
Measles	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____
German Measles	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____	Whooping Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____
Mumps	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____	HIV (AIDS)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____
Chicken Pox	<input type="checkbox"/> No	<input type="checkbox"/> Yes, (complete date) ___/___/___	Malaria	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Year _____

Please indicate if your child suffers any of the following conditions:

ASTHMA	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Treatment _____
EAR PROBLEMS	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Treatment _____
EYE PROBLEMS	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Treatment _____
EPILEPSY	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Treatment _____
DIABETES	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Treatment _____
OTHER _____		Treatment _____

Please indicate if you child has had any:

Operations	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Describe _____
Injuries or Accidents	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Describe _____
Regular Medications	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Medication Name	Dosage	Condition being treated

It is important that the school nurse and dormitory staff know of all the medications taken by the student. All medications student have must be in the original container labeled with the student's name, physician, date, name of medication and dosage. Instruction of change of the dosage must be in writing from the prescribing doctor. All medications administered by the school nurse will be recorded.

Please note we do not permit student to have medication in their possession, with the exception of asthma puffers. ALL MEDICATION WILL BE KEPT IN THE NURSE'S OFFICE. Your cooperation in this matter would be appreciated.

REQUIRED IMMUNIZATION

If this information is not available, the School will administer the required/recommended vaccines at the expense of the parents. Thanks You.

Vaccine	DATE EACH DOSE WAS GIVEN				TB Test Date _____ Result: _____ mm ----- or ----- BCG vaccine Date _____
	1 st	2 nd	3 rd	4 th	
POLIO – SABIN (OPV/ IPV)					
DTP/DTaP/DT/ TD (Diphtheria, Tuberculosis and Pertussis)					
TD/TDaP WITHIN LAST 10 YEARS					
MMR (Measles, Mumps, and Rubella)					
HEPATITIS A					
HEPATITIS B					
CHICKEN POX (Varicella)		My child had the chicken pox on (complete date) ___/___/___			
INFLUENZA (Seasonal) /(SWINE)		Not required by state but highly recommended. Should be given every year.			
MENINGITIS		My child had the vaccination on complete date ___/___/___			

With a family the size of ours, at the school there is always a possibility of an outbreak of some contagious disease. For this reason, we require all the immunizations be kept current. We request your signature below to permit the administering of immunizations or skin tests that may be recommended by the school. If you don't want your child to receive a recommended vaccine please state it on this form or in writing for our records. I also give permission for my child to receive non-prescription medicine at the school for treatment of minor conditions and illness, at the best judgment of school nurse and staff.

Date

Signature of Parent or Guardian

Student's Name: _____

Health Record

Class Year: _____

PHYSICAL EVALUATION

THIS FORM MUST BE COMPLETED FOR EVERY STUDENT and **annually** by parents or guardian of student who intends to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Explain any "YES" answer in the space below. Circle the questions you do not know the answer for. Any YES answer in questions 1 through 18 requires medical evaluation, including a physical examination. Written clearance is required before any participation in any practices, games or matches.

1. Have you had any medical illness or injury since your last check up or sport physical? YES NO
 2. Have you been hospitalized overnight in the past year? YES NO
 3. Have you ever passed out during or after exercise? YES NO
 4. Have you ever had chest pain during or after exercise? YES NO
 5. Do you get tired more quickly than your friends do during exercise? YES NO
 6. Have you ever had racing of your heart or skipped heartbeats? YES NO
 7. Have you had high blood pressure or high cholesterol? YES NO
 8. Have you been told you have a heart murmur? YES NO
 9. Have any family member or relative died of heart problem or of sudden unexpected death before age 50? YES NO
 10. Has a physician ever denied or restricted your participation in sports for any heart problem? YES NO
 11. Have you ever had a head injury or concussion? YES NO
 12. Have you ever been knocked out, become unconscious or lost your memory? YES NO
 13. Have you ever had a seizure? YES NO
 14. Do you have frequent or severe headaches? YES NO
 15. Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO
 16. Have you ever had a stinger, burner or pinched nerve? YES NO
 17. Are you missing any paired organs? YES NO
 18. Are you under a doctor's care? YES NO
 19. Have you ever been dizzy during or after exercise? YES NO
 20. Do you have any current skin problem? YES NO
 21. Have you ever become ill from exercising in the heat? YES NO
 22. Have you ever gotten unexpectedly short of breath with exercise? YES NO
 23. Do you use any special protective or corrective equipment or device? YES NO
 24. Have you ever had a sprain, strain, or swelling after injury? YES NO
 25. Have you ever broken or fracture any bones or dislocated any joint? YES NO
 26. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? YES NO
 27. Do you want to weigh more or less than you do now? YES NO
 28. Do you lose weight regularly to meet weight requirements for your sport? YES NO
 29. Do you feel stressed out? YES NO
 30. Have you ever been diagnosed with or treated for sickle cell trait or disease? YES NO
- Females only
31. Do you have irregular periods? YES NO
 32. Do you have severe cramps or excessive flow? YES NO

Please explain "YES" answers in this box.

I, the undersigned parent or legal guardian, state that to the best of my knowledge, my answers to the above questions are complete and correct. Hereby, I authorize the child's full participation in the Presbyterian Pan American School athletic program. It is my understanding that participation in the activities that make up the PPAS athletic program are not without some inherent risk of injury. As such, in consideration of my child's participation in the PPAS athletic program, I hereby release, waive, discharge and covenant not to sue Presbyterian Pan American School, the Athletic department or employees from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage or injury, including death, that may be sustained by my child, whether caused by the negligence of releases, or otherwise while participating in such activity, or while in, on or upon the premises where the activity is being conducted.

I also agree to follow instructions and procedures in order to maintain a maximum lever of safety. I also understand that a medical insurance policy carried by Presbyterian Pan American School will provide only minimum coverage and that I should be aware that medical costs that accrue in the event of an injury will be my responsibility.

I give permission for emergency medical care and any in or outpatient procedures or exams ordered by a physician, including transportation and accept responsibility for the cost.

Student Signature

Parent's or Guardian's Signature

Date

Health Record

Class Year: _____

Student's Name: _____

PHYSICAL EXAMINATION

Height _____ Weight _____ % Body Fat _____ Pulse _____ BP _____/_____

Vision R 20/ _____ L 20/ _____ Corrected: YES NO Pupils: Equal Unequal

As a minimum requirement, this Physical Examination Form must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It must also be completed if there are yes answers to the specific question on the student's Physical Evaluation form (Page 3).

MEDICAL	Normal	Abnormal Findings	Initials (station-based examination only)
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- supine position			
Heart- Standing position			
Heart – lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back (scoliosis exam)			
Shoulder/Arm			
Wrist/ Hand			
Hip/Thigh			
Knee			
Leg/ Ankle			
Foot			

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Physician's Signature

Printed Last Name

Address

Date