OUR LADY OF LOURDES HIGH SCHOOL

Physical Examination/Health Certificate

(Required for all new entrants to OLL & students in grade 10 → **DUE within 30 days of starting school!**)

Name: ____ **Date of Birth:** _____________________ **Grade:** ______________

HEALTH HISTORY: To be completed by physician/health care provider

Current diseases/conditions: ❒ Asthma ❒ Diabetes: ___Type 1 ___Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Cardiac Condition: Type ________________________________ ❒ Seizure Disorder: Type ________________________________
❒ Other ____

Current Medications taken at home: ____

Significant Medical/Surgical History: ____

❒ Vision one eye only ❒ One functioning kidney ❒ One testicle ❒ Concussion – last occurrence________________________

Allergies to Medications: ____

Allergies: ❒ Food LIFE THREATENING: Yes ❒ No ❒ Specify food____

❒ Insect LIFE THREATENING: Yes ❒ No ❒ Specify insect____
❒ Other LIFE THREATENING: Yes ❒ No ❒ Specify____
❒ Seasonal ____

Current Medications taken at home: ____

PHYSICAL EXAM

Date of Exam: _________________ **Height:** _________________ **Weight:** ________________ **Blood Pressure:** ________________

Body Mass Index: __________________ . _________

Weight Status Category (BMI Percentile):

❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

	Right	Left	
Vision: without correction			❑ Referred
Vision: with correction			❑ Referred
Hearing: Pure Tone Screening			❑ Referred

Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive Dental Referral: Yes ❒ No ❒

Yes ❒ No ❒ EXAM ENTIRELY NORMAL. Specify any abnormality: ____
____

Yes ❒ No ❒ Student is free of communicable disease and is physically qualified for all physical education, work & routine school activities.

Limitations/Restrictions:____

MEDICATION ORDER (S)FOR SCHOOL

Medication required for school or sports, i.e. Inhaler, EpiPen, Glucagon, etc.

❒ None ❒ Attached - Complete the attached, *Licensed Prescriber's Medication Order.*)

SPORTS CLEARANCE
(Subject to final review and approval per requirements of the current policy for interscholastic sports participation)

I have reviewed this student's history & conducted a physical exam for participation in interscholastic sports competition.

Yes ❒ No ❒ **Full Activity - This student is physically qualified for full activity in ALL SPORTS without restriction.**

❒ **Restrictions/Limitations:** Specify____
____

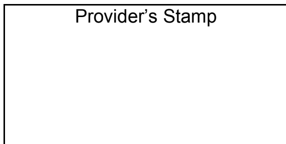
Protective equipment required: Specify ____

Reason for Disqualification: ____

Provider's Signature: _______________________________ Date: ______________________

Provider's Name:_______________________________ Phone: ______________________

Provider's Address: _______________________________ Fax: ______________________


Provider's Stamp

PLEASE ATTACH AN UPDATED COPY OF THE STUDENT'S IMMUNIZATION RECORD.

Our Lady of Lourdes High School
131 Boardman Rd Phone (845) 463 - 0400
Poughkeepsie, NY Fax (845) 463 - 0192

Medication Order Form

A **provider order** and **parent/guardian permission** are required for all medications administered at school and/or at school sponsored activities.

Additional provider attestation is required for a student to independently carry and use a medication such as inhaled respiratory rescue medication, epinephrine auto injector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration.

Student Name_____________________________________ **DOB**_______________ **Grade/Class**________

Health Care Prescriber Medication Order.

Diagnosis: ____

Medication: ____

Dose & Route: ____

Time: ____

This medication order is *valid for a period of one year* unless otherwise specified here:

____

Provider Permission for Self-Carry and Self-Administration:

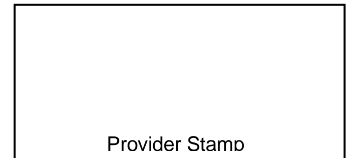
❒ **No** ❒ **Yes**, I attest that this student has demonstrated that they can self-administer the medication(s) listed above effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Provider's Signature____ Date _____________________

Provider's Name____

Provider's Address ____

Phone_____________________________ Fax___________________________


Provider Stamp

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Parent/Guardian Permission for Medication

Review and sign *only one* of the following:

Option A. For a student with provider permission to self-administer and carry.

I agree that my child can self-administer and will carry the medication as prescribed above.

Parent/Guardian Signature_______________________________________ Date_____________________

OR

Option B. For a student without provider permission to self-administer and carry. (See above.)

I give permission for my child to receive the medication prescribed above. I understand that I must bring the medication to the school nurse in the original pharmacy or over the counter container.

Parent/Guardian Signature____ Date___________________