Health Record
Class Year:

Presbyterian Pan American School

Kingsville, Texas 78363 **(This page must be completed by the Parents)**

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

Home Address_____

_____

Date of birth _____ Religion _____Blood group_____

Health Insurance _____ Group Number_____ Policy Number _____

FATHER'S INFO

Name _____ Phone Number (cell/home)_____

E-mail _____Phone Number (work) _____

MOTHER'S INFO

Name _____ Phone Number (cell/home)_____

E-mail _____Phone Number (work) _____

IN CASE OF EMERGENCY IF PARENT CANNOT BE CONTACTED, PLEASE NOTIFY THE PERSON LISTED BELOW

(Name and Relationship)**:**_____

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

Phone Number (cell)_____ 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_____

Most recent Tetanus immunization ___,___,___(school nurse will fill in)

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 permission on my behalf for any medical care for inpatient or outpatient procedures including anesthetics and blood transfusions if necessary, with the understanding that I will be notified as soon as possible.

_____ _____

Date Signature of Parent or Guardian

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(Parents must complete this page)
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. (Eye and Dental exams should be done yearly while at home and submitted to the school nurse.)

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

Scarlet Fever	☐ No	☐ Yes, Year _____	Tuberculosis	☐ No	☐ Yes, Year _____
Measles	☐ No	☐ Yes, Year _____	Hepatitis	☐ No	☐ Yes, Year _____
German Measles	☐ No	☐ Yes, Year _____	Whooping Cough	☐ No	☐ Yes, Year _____
Mumps	☐ No	☐ Yes, Year _____	HIV (AIDS)	☐ No	☐ Yes, Year _____
Chicken Pox	☐ No	☐ Yes, (complete date) ___/___/___	Malaria	☐ No	☐ Yes, Year _____

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

ASTHMA ☐ No ☐ Yes, Treatment _____
EAR PROBLEMS ☐ No ☐ Yes, Treatment _____
EYE PROBLEMS ☐ No ☐ Yes, Treatment _____
EPILEPSY ☐ No ☐ Yes, Treatment _____
DIABETES ☐ No ☐ Yes, Treatment _____
OTHER _____ Treatment _____

Please indicate if you child has had any:

Operations ☐ No ☐ Yes, Describe_____
Injuries or Accidents ☐ No ☐ Yes, Describe_____
Regular Medications ☐ No ☐ 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 belonging to any student must be 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, unless nurse gives permission.**
ALL OTHER MEDICATIONS WILL BE KEPT IN THE NURSE'S OFFICE.

REQUIRED IMMUNIZATION
(*Must* have Month day and year to be valid)

Please fill in all the information possible, if this information is not available, the School may administer vaccines at the expense of the parents. The student's Doctor must provide a signature, date and stamp in the portion below as indicated in order to validate the information entered. Certain Immunizations are required prior to the student's arrival into the United States of America.

Vaccine	DATE EACH DOSE WAS GIVEN 1st	2nd	3rd	4th	TB Test
POLIO/SABIN (OPV/ IPV) **one after 4th birthday**					Date _____
DTP/DTaP/DT/ TD (Diphteria, Tuberculosis and Pertussis)					Result:_____mm
Tdap LAST 10 YEARS					---------- or ----------
MMR (Measles, Mumps, and Rubella)					**BCG vaccine**
HEPATITIS A					Date_____
HEPATITIS B					
CHICKEN POX (Varicella)			**My child had the chicken pox on** (complete date) ___/___/___		
Influenza vaccine		**Will be given at the school if available yearly, you may decline in writing.**			
MENINGITIS					

►►► **Validate immunizations with Dr's signature, date and stamp. →→→**
****Attach vaccination record to this document.**

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. I give permission for my child to receive non-prescription medicine at the school for treatment of minor conditions and illness.

_____ Date

_____ Signature of Parent or Guardian

(Parents must complete this page)

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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 you had any relative die of a 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 devise? ☐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 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 level 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 any medical care or treatment by physician, surgeon, hospital or medical care facility that may be required including transportation and accept responsibility for the cost.

_____	_____	_____
Student Signature	Parent's or Guardian's Signature	Date

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Student's Name: _____

PHYSICAL EXAMINATION (Completed by a Doctor)

Height_____ **Weight** _____ **% Body Fat**_____ **Pulse** _____ **BP** _____/_____

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

Physical Examination Form must be completed by a Doctor prior to enrollment and every successive year the student participates in any athletic team. It must also be completed if there are "yes" answers to any specific questions on the student's Physical Evaluation form (Page3).

►***This form must be used. Letters from Doctors will not be accepted.***◄

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: _____

_____

Place Here

_____ Stamp _____
Physician's Signature or Seal Printed Last Name

_____ _____
Address Date