HOLY SPIRIT PREPARATORY SCHOOL
PRESCHOOL & LOWER SCHOOL
STUDENT HEALTH RECORD 2016-2017

This record is to be completed by Parent/Guardian and signed by student's physician. The record must be returned to the school clinic no later than July 31, 2016. For students in any grade entering HSPS for the first time, a Georgia Certificate of Immunization, Form 3231, MUST be completed for school attendance. For returning students Pre-K and entering grades K, 3 & 6, and updated Form 3231 MUST be provided for school attendance. A sample Form 3231 is included with this form. An original must be obtained, stamped and signed by your physician. Please fill out this record completely. Mark N/A if not applicable.

Entering Grade _____ in August 2016 Status: (check one) _____New Student _____Returning Student

Student's Name _____ Date of Birth _____-_____-_____

PARENT OR GUARDIAN INFORMATION – RESIDING WITH STUDENT

Parent/Guardian Name(s) _____ Relationship _____

Student's Home Address _____
City _____ State _____ Zip Code _____
Home Phone (_____) _____
Fax (_____) _____
Email Address _____@ _____

Mother's Business Phone (_____) _____ Father's Business Phone (_____) _____

Mother's Cellular Phone (_____) _____ Father's Cellular Phone (_____) _____

Additional Contact Numbers _____

PARENT OR GUARDIAN INFORMATION – NOT RESIDING WITH STUDENT

Parent/Guardian Name(s) _____ Relationship _____

Student's Home Address _____
City _____ State _____ Zip Code _____
Home Phone (_____) _____
Fax (_____) _____
Email Address _____@ _____

Business Phone (_____) _____ Cellular Phone (_____) _____

EMERGENCY CONTACTS – IF WE ARE UNABLE TO REACH PARENT/GUARDIAN

Name _____ Relationship _____
Home Phone _____Cellular/Other Phone (_____) _____

Name _____ Relationship _____
Home Phone _____Cellular/Other Phone (_____) _____

HEALTH PROVIDER & INSURANCE INFORMATION

Health Insurance Company _____ Policy / Group # _____

ALLERGIES

Does student have any allergies to? Check Yes or No. If yes is checked, please explain.

Yes	No	
◇	◇	Medications: _____
◇	◇	Foods/Beverages: _____
◇	◇	Insects: _____
◇	◇	Insects/Other: _____
◇	◇	Requires EpiPen (parent to provide:_____

MEDICAL HISTORY OF STUDENT

MUST be completed by Parent / Guardian

Student's Name _____ **Date of Birth** _____/_____/_____
Physician's Name _____ **Phone # (_____)** _____
Dentist's / Orthodontist's Name _____ **Phone # (_____)** _____

Does student have any current problem or history of: (if yes, please explain)

Yes	No	
◇	◇	Asthma (if yes, check type) Exercise – induced: _____ Seasonal: _____ Other: _____
◇	◇	Uses inhaler at school (if yes, how often & what type)_____

If using inhaler at school, an extra inhaler must be provided to the clinic.

◇	◇	Arthritis/Bone or Joint Disease _____
◇	◇	Blood Disorders/Anemia _____
◇	◇	Cancer _____
◇	◇	Diabetes (if yes, type of insulin) _____
◇	◇	Insulin _____
◇	◇	Epilepsy / Seizures (if yes, medication used) _____
◇	◇	Medications Used _____
◇	◇	Heart Murmur / Cardiac Disease _____
◇	◇	History of Head Injury / Headaches _____
◇	◇	History of Migraines (if yes, medication used) _____
◇	◇	Kidney Disease _____
◇	◇	Lung Disease _____
◇	◇	History of Broken Bone(s) _____
◇	◇	History of Orthopedic Problems or Surgery _____
◇	◇	Skin Conditions/Problems _____
◇	◇	Chronic Illness (explain) _____
◇	◇	Other _____
◇	◇	Visual Problems / Contacts or Eyeglasses (circle one or both) _____
◇	◇	Additional Details History: _____

Does the student take any medications regularly? _____ (if yes please list type and dosage of medication)
Name of Medication(s) _____
Will these medications be taken at school? _____
Reason for Medication(s) _____

Please Note: For medications that will be administered by the nurse or a designated school staff member at school, the parent and physician must complete the "Authorization to Administer Medications" form, including an EpiPen, inhalers, diabetic supplies and medications.

OVER-THE-COUNTER MEDICATIONS

Indicate below which over-the-counter medications we may give your child.

Yes	No		Yes	No	
◇	◇	Tylenol (brand or generic)	◇	◇	Ibuprofen (Motrin or Advil)
◇	◇	Antacids	◇	◇	Benadryl (oral or topical for allergic reactions)
◇	◇	Hydrocortisone Cream	◇	◇	Benadryl (spray / cream)
◇	◇	Triple Antibiotic (ointment / cream)			

AUTHORIZATION AND CONSENT TO ADMINISTER MEDICATIONS AND MEDICAL TREATMENT

Understanding that my child may need emergency treatment during school hours or while at school activities, I authorize the school through its nurse or other qualified person, to administer such first aid and/or other minor medical treatment as shall be deemed best under the circumstances, **including but not limited to the use of an EpiPen for severe allergic reactions**, and I consent for my child to receive such treatment. I understand that certain emergencies may require such prompt and immediate attention to my child that nursing or other qualified assistance may not readily be available and I therefore understand that any school employee may provide emergency assistance to my child. I understand that in the event of an emergency requiring immediate medical care, the school will attempt to notify me or any other legal guardian of my child and if the school is unable to notify me, I understand that the school may seek emergency services for my child without notification to me and I consent to have my child treated by a duly qualified physician at the nearest hospital or other emergency facility. In addition, I hereby request that Holy Spirit Preparatory School, through its designated authority, assist, supervise and/or administer the over-the-counter medications indicated in this document as well as any prescription or nonprescription medications I have requested be given to my child by submitting an *Authorization to Administer Medications* form. I release the Board of Trustees, school, and any school employee from liability for administering medications and first aid to my child and I agree to hold harmless, indemnify the school, its employees and agents either jointly or severally, from and against any and all claims, damages, causes of action or injuries arising from the medication of my child while at school or at school-sponsored events. I acknowledge that it is my responsibility to keep my child's records current to reflect any allergies, medical/physical conditions, and communicable diseases. I also understand that the obligation to provide medical insurance for my child rests with me as a parent or guardian.

_____

Parent/Guardian Signature *Date*

STUDENT'S ANNUAL PHYSICAL EXAM

This exam must be completed by a physician and dated between May 1, 2016 and July 31, 2016.

ALL STUDENT ATHLETES MUST HAVE A PHYSICAL ON FILE BEFORE BEGINNING PRACTICE.

ALL NEW Students MUST have a Current 3231 Immunization Form Completed.
Current Students, please complete an updated form if a New Booster Immunization is received.

STUDENT'S NAME: _____ **AGE:** _____ **DOB:** _____

VITAL SIGN/STATISTICS

_____ **Height**	_____ **Resting Pulse**
_____ **Weight**	_____ **Pulse (immediately post exercise)**
_____ **B/P (resting)**	_____ **Pulse (after brief rest period)**

REVIEW OF SYSTEMS

Head/Neck: _____ **Spine:** _____
Lungs: _____ **Extremities:** _____
Heart/Murmurs:_____ **Other:** _____
Abdomen/Hernia: _____

The physical examination was completed and the student was found to be free of communicable diseases.	**YES or NO**
The student was checked for scoliosis, scapula prominence and shoulder tilt.	**YES or NO**
The student's vision and hearing are normal.	**YES or NO**
The student may fully participate in physical education and in all athletic activities.	**YES or NO**

Student's General Condition: (check one) _____**Excellent** _____**Good** _____ **Fair** _____ **Poor**

PHYSICAL EDUCATION & EXTRACURRICULAR ATHLETICS

_____ Student is cleared for **full participation** in physical education and all athletics.
_____ Student is **not cleared** for full participation in physical education and all athletics. Explain limitation / exemption: _____
_____
_____ Student is cleared to participate in physical education and all athletics **after completing evaluation / rehabilitation** for: _____
_____

Date of Exam: ____/____/____

Physician's Signature: _____

Physician's Stamp:

Phone #: (_____)_____
Fax #: (_____)_____

Form **3231** (Rev. 03/2007)
Use required on or after July 1, 2007.

Georgia Department of Human Resources

Form **3231**

CERTIFICATE OF IMMUNIZATION

Lastname, Firstname I.
Child's Name (Last name first)

10 | 01 | 2001
Birthdate

Lastname, Mother I.
(Optional) Parent/Guardian Name (Last name first)

Date of Expiration
(Next required immunization or review of medical exemption due.)

OR

X (Fill in X)
Complete For School Attendance
Child must be ≥ 4 years and have met all requirements for school attendance. The vaccine history section must be filled in.

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Program.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology +	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP, DTaP, DT											
Td or Tdap											
Hepatitis B											
OPV											
IPV											
HIB (Under Age 5)											
PCV (Under Age 5)											
Measles											
Mumps											
Rubella											
Hepatitis A (Born on/after 1/1/06)											
Varicella											
Recommended Vaccines (For Information Only)											
MCV/MPSV											
Rotavirus											
HPV											
Influenza											
Td or Tdap (Booster Dose)											

SAMPLE

Notes:
A licensed physician or qualified employee of a local Board of Health or the State Immunization Program is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in in the appropriate box(es). ***The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician or health department, certified by signature and a date of issue.*** A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. ***When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.***

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Dept.

Sample Q. Physician, M.D. P.C.
1234 Some Street
Fictitious Town GA 99999-9999

(555) 123-4567

Sample Q. Physician, M.D.
Certified by (Signature)

12 | 01 | 2006
Date of Issue