HOLY SPIRIT PREPARATORY SCHOOL
UPPER 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 entering HSPS for the first time, a Georgia Certificate of Immunization, Form 3231, MUST be completed for school attendance. Any returning HSPS students MUST return a completed, Form 3231, if not already on file 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*

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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									X		
OPV											
IPV											
HIB (Under Age 5)											
PCV (Under Age 5)											
Measles									X		
Mumps									X		
Rubella									X		
Hepatitis A (Born on/after 1/1/06)											
Varicella											
Recommended Vaccines (For Information Only)											
MCV/MPSV											
Rotavirus											
HPV											
Influenza											
Td or Tdap (Booster Dose)											

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