MEDICAL INFORMATION AND PHYSICAL EXAMINATION FORM FOR INCOMING STUDENTS 2020-2021

ALL INCOMING STUDENTS MUST SUBMIT A PHYSICAL EXAMINATION FORM— PHYSICALS COMPLETED PRIOR TO APRIL 2020 WILL NOT BE ACCEPTED.

In compliance with KRS 158.035, KRS 214.0, and KAR 2:060
the original certificate of immunization against diphtheria, tetanus, poliomyelitis, measles, rubella, hepatitis A, and meningitis
must be submitted by every student and kept on file by the school.

Student's final admission status is not complete until the physical examination form and the required certificate of immunization status have been submitted.

Important Information for Incoming Students Planning to Participate in Athletics

- ✓ **In accordance with KHSAA regulations, the student's medical history and physical must be reported on the KHSAA form which follows.**
- ✓ **Students trying out for CHEERLEADING AND DANCE:** physical examination must be completed and health forms turned in prior to tryouts in mid-April. If the physical was conducted between April 2019 and March 2020, it will satisfy the KHSAA requirement, but a current physical examination, conducted April-July 2020, is required by July 30, 2020, to meet the school requirement.

PART 1 - STUDENT INFORMATION

Student's Full Legal Name: _____
Last First Middle 2020-2021 Grade

Student's Home Address: _____
Number & Street City State Zip Code

Student's Date of Birth: _____ Student's Social Security #: _____

Primary Physician _____ Office Phone # _____

Family Dentist _____ Office Phone # _____

PART 2 – PARENTAL PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION/ PARENTAL CONSENT/PERMISSION TO TREAT AUTHORIZATION – 2020-2021

Parent/guardian signatures are required in order for your daughter to receive any necessary medical treatment or medication (including Tylenol, Advil, etc.).

In the event of an injury or illness during the school day or at a school event or, if applicable, an athletic event or practice session, I give permission for my daughter, _____, to receive proper/necessary care from the school nurse, staff member, certified athletic trainer, or coach. In addition, I authorize treating physicians and/or their representatives to release medical information to representatives of the Assumption Administration, Athletic Department, and coaching staff, as applicable.

In the event of an emergency during the school day or at a school event or, if applicable, an athletic event or practice session, I give permission for my daughter, _____, to be transported to an appropriate medical facility for treatment. Furthermore, I give permission for the staff at the medical facility to render any and all treatment that is necessary for the well-being of my daughter. In addition, I authorize treating physicians and/or their representatives to release medical information to representatives of the Assumption Administration, Athletic Department, and coaching staff, as applicable.

Signature: _____ **Date:** _____

New Kentucky Immunization Laws

The following is a summary of the recent changes, effective June 21, 2017, to 902 KAR 2:060:
Immunizations schedules for attending child day care centers, certified family child care homes, other licensed facilities which are for children, preschool programs, and public and private primary and secondary schools, https://www.lrc.ky.gov/kar/902/002/060.htm . This amended Kentucky Administrative Regulation requires all children to have a current immunization certificate on file, contains the required immunizations schedule for attending, and has a process to obtain a religious exemption from the required immunizations.

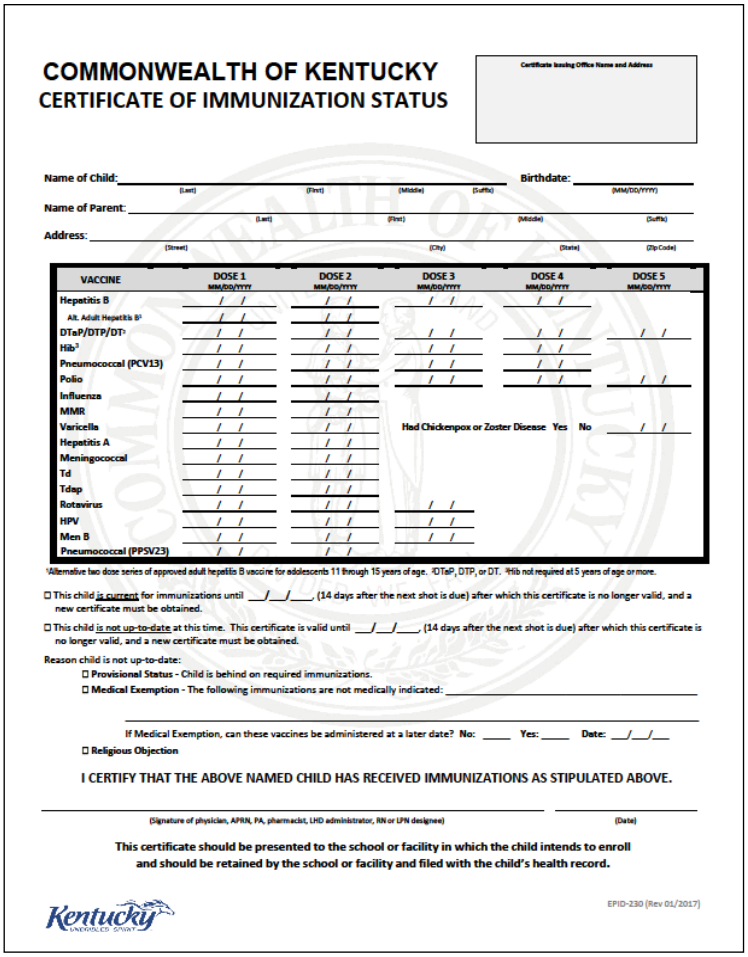
- One new age-specific immunization requirement and one booster dose requirement effective for the school year beginning on or after July 1, 2018:
  - 2-Dose Series of Hep A (Age: 12 months through 18 years, to be compliant for the series the second Hep A is given six months after the first inject.)
  - Quadrivalent meningococcal vaccine (MenACWY) booster dose (Age: 16 years)
- Homeschooled children are required to submit to current immunization certificate to participate in any public or private school activities (classroom, extra curriculum activity, or sports).
- All vaccines administered are printed on the Commonwealth of Kentucky Certificate of Immunization Status now including immunizations not required for school entry.

- Out of state immunization certificates may be accepted if they meet the same age – specific requirements as outlined in this regulation.

- A Commonwealth Certificate of Immunization Status printed from the Kentucky Immunization Registry (KYIR) does not require a signature

- Routine certificate reviews are to occur at enrollment in a day care center, kindergarten, new enrollment at any grade; upon legal name change; and at a school required examination pursuant to 702 KAR 1:160.

- A child whose certificate has exceeded the date for the certificate to be valid shall be recommended to visit the child's medical provider or local health department to receive immunizations required by this administrative regulation. An updated and current certificate shall be provided to the:
  - Day care center, certified family child care home, or other licensed facility that cares for the children by a parent or guardian within thirty (30) days from when the certificate was found to be invalid.
  - School by a parent or guardian within fourteen (14) days from when the certificate was found to be invalid.



COMMONWEALTH OF KENTUCKY
CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ Birthdate: _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (ZipCode)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B[1]	/ /	/ /			
DTaP/DTP/DT[2]	/ /	/ /	/ /	/ /	/ /
Hib[3]	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /			
MMR	/ /	/ /			
Varicella	/ /	/ /	Had Chickenpox or Zoster Disease Yes No		/ /
Hepatitis A	/ /	/ /			
Meningococcal	/ /	/ /			
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /			

[1]Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. [2]DTaP, DTP, or DT. [3]Hib not required at 5 years of age or more.

☐ This child is current for immunizations until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

☐ This child is not up-to-date at this time. This certificate is valid until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:
☐ **Provisional Status** - Child is behind on required immunizations.
☐ **Medical Exemption** - The following immunizations are not medically indicated: _____

If Medical Exemption, can these vaccines be administered at a later date? No: ____ Yes: ____ Date: ___/___/___

☐ **Religious Objection**

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee) (Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky UNBRIDLED SPIRIT

EPID-230 (Rev 01/2017)

Please return completed forms to the School Office by Thursday, July 30, 2020

Physical Education/Athletic Participation Form
Parental and Student Consent and Release
For High School Level (grades 9-12) participation

KHSAA Form GE04
High School Parental Permission and Consent
Rev. 7/19, page 1 of 2

*The student and parents/guardian must read this statement carefully and sign where required. By signing this form, all parties agree that they have accurately completed all sections of the form and have read and agree to the terms of this form as detailed. This form **must** be completed before the student participates (hereinafter including try out for, practice and/or compete) in interscholastic athletics/physical education. This form should be kept in a secure location until the student has exhausted eligibility, graduated from high school and reached the age of 19.*

STUDENT/ATHLETE INFORMATION *(This part must be completed by the student and family)*

Name (Last, First, Initial) _____ School Year _____

Home Address (Street, City, State, Zip): _____

Gender _____ Grade _____ School _____

Date of Birth: _____ Birth Place (County, State): _____

School Attendance History

Grade	School Name	School Year		Varsity Play – (Yes/No)?
9				
10				
11				
12				

I am planning to participate in the following (check all you might try to play):

☐ Baseball	☐ Basketball	☐ Cross Country	☐ Football	☐ Golf	☐ Soccer
☐ Softball	☐ Swimming	☐ Tennis	☐ Track and Field	☐ Volleyball	☐ **NONE**
☐ Archery	☐ Dance	☐ Bowling	☐ Competitive Cheer	☐ Other _____	

EMERGENCY CONTACT INFORMATION

_____ _____
Name (please print) Relation to Student

_____
Emergency Contact Address, including City, State and Zip

_____ _____
Daytime Phone Cell Phone

FOR ATHLETES: REQUIRED INSURANCE INFORMATION (KHSAA Bylaw 12)

Prior to participation in practice or contests (including trying for a place on a team) in any sport or sport activity during the limitation of seasons as defined in Bylaw 23, all students are required to have medical insurance with coverage limits of at least $25,000. If this coverage is provided through the school, contact the Principal or Athletic Director regarding any potential claim. Individual schools and districts may impose additional requirements for insurance or coverage during additional periods for activities outside of Bylaw 23.

Insurance Carrier _____ Policy Number / ID Number _____ Group Number _____ Plan _____

EMERGENCY TREATMENT INFORMATION

The following information is recorded solely for potential hospitalization and emergency care needs and is not required to be recorded on this form. However, those failing to provide this information should be aware that this might be required by emergency treatment facilities prior to rendering service, and failure to provide could result in lack of appropriate care.

_____ _____
Social Security Number Birth Date

CONSENT INFORMATION TO PARTICIPATE, ACKNOWLEDGMENT OF RISK, ACKNOWLEDGEMENT OF ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE

As parent/legal guardian, I agree to allow my child to participate in interscholastic athletics and/or physical education.

The student and parent/legal guardian recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries, including but not limited to death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to internal organs, serious injury to bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and

serious injury or impairment to other aspects of the body, or effects to the general health and well being of the child. Because of these inherent risks, the student and parent/legal guardian recognize the importance of the student obeying the coaches' instructions regarding playing techniques, training and other team rules. By signing this form, the student and parent/legal guardian acknowledge that the student's participation is wholly voluntary and to having read and understood this provision.

The student and parent/legal guardian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and forever discharge the KHSAA and its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or parent/legal guardian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

The student and parent/legal guardian acknowledge that they have read and understood the KHSAA Bylaws by distribution under the handbook links at http://khsaa.org/. Please be aware that a student is subject to the one-year period of ineligibility the bylaw commonly referred to as the "Transfer Rule," upon participation in any varsity contest regardless of the amount of participation or lack thereof.

The student and parent/legal guardian agree to abide by the KHSAA Bylaws and Due Process Procedure as now enacted or later amended. The student and parent/legal guardian further acknowledge that they agree to abide by the rulings of the Commissioner, Assistant Commissioner, Hearing Officer and Board of Control.

The student and parent/legal guardian acknowledge that the student must have medical insurance coverage up to a limit of $25,000 in order to be eligible to participate in interscholastic athletics.

The student and parent/legal guardian, individually and on behalf of this student, give the high school, the KHSAA and their representatives permission to release this student's demographic information (including motion picture and still photographic images) and participation statistics (including height, weight and year in school, participation history and other performance based statistics) and other information as may be requested, and agree that the student may be photographed or otherwise digitally or electronically captured during school-based competition. All of this material may be used without permission or compensation specifically related to the KHSAA and its events.

The student and parent/legal guardian consent to this student receiving a physical examination as required by the KHSAA.

The student and parent/legal guardian, individually and on behalf of this student, consent to the high school and the KHSAA and their representatives to use and disclose the necessary personally identifiable information from the student's education records including academic, financial and health care information, to third parties including school representatives, coaches, athletic trainers, medical facilities, medical staffs, KHSAA legal counsel and the media, for the purpose of receiving proper/necessary medical care and complying with the KHSAA bylaws, including making determinations regarding eligibility to participate in interscholastic athletics and any administrative or legal proceedings resulting from participation or attempted participation in interscholastic athletics, without such disclosure constituting a violation of rights under the Family Educational Rights and Privacy Act. The student and parent/legal guardian, individually and on behalf of this student, further release the high school, the KHSAA and their representatives from any and all claims arising out of the use and disclosure of said necessary personally identifiable information, and agree to release to the high school, the KHSAA, and their representatives, upon request, the detailed and completed application for financial aid.

The student and parent/legal guardian, individually and on behalf of the student, hereby acknowledge that they are aware of and will review if desired, the education materials available through the KHSAA, the Centers for Disease Control and other agencies regarding education all individuals with respect to nature and risk of concussion and head injury, including the continuance of play after concussion or head injury.

The student and parent/legal guardian, individually and on behalf of the student, hereby consent to allow the student to receive medical treatment that may be deemed advisable by the high school, the KHSAA, and their representatives in the event of injury, accident or illness while participating in interscholastic athletics, including, but not limited to, transportation of the student to a medical facility.

STUDENT AND PARENT/GUARDIAN ACKNOWLEDGMENT OF RISK, ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE AND EMERGENCY PERMISSION FORM

Students' Name (please print) _____ School _____

Student and Parent/Guardian Address including City, State and Zip _____

Signature of Student _____ Date _____

Please list above any health problems/concerns this student may have, including allergies (medications / others) and any medications presently being used

Name of Parent(s)/Guardian(s) who has/have custody of this student (please print) _____ Emergency Phone Number _____

Signature of Parent(s)/Guardian(s) who has/have custody of this student _____ Date _____

Please return completed forms to the School Office by Thursday, July 30, 2020

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex at birth (F, M): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of student/athlete:_____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN/STATUTORILY AUTHORIZED PROVIDER 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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart ** • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

** Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports/participation in physical education without restriction

☐ Medically eligible for all sports/participation in physical education without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports/participation in physical education

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports/participation in physical education

Recommendations: _____

_____

_____

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

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

ASTHMA AUTHORIZATION FORM 2020-2021

If your daughter has asthma, this form must be completed, signed, and returned to the School Office by **Thursday, July 30, 2020**.

Kentucky House Bill 353 allows students with asthma to have unobstructed access to asthma medications. The key points of this law are as follows: Public and private school students are allowed to possess and use asthma medications provided that:

- The student has written authorization from a parent and her health care provider to self-administer her asthma medications.
- The written authorization is kept on file at school.
- A parent or guardian must sign a statement acknowledging that the school has no liability from any injury sustained by a student from self-administration of medication.
- Permission for self-administration of medications is effective for the current school year and must be renewed each school year.

If you have any questions regarding this law or any asthma issue, please contact the Director of Education & Advocacy, American Lung Association, at 363-2652.

STUDENT NAME: _____ STUDENT I.D. #_____
(PRINT): Last First Middle (office use only]

If your daughter has asthma, but does NOT need to self-administer asthma medications at school,

complete and sign only this section of the form and return the signed form to the School Office.

I,_____, parent/guardian of the above named student, verify that my daughter has asthma, but does not need to carry or self-administer any asthma medications at school, at school-sponsored activities or at any time that she is present on Assumption High School's property.

Signature:_____ Date:_____

If your daughter has asthma and must self-administer asthma medications at school,

the parent and the student's health care provider must complete and sign all sections below.
You must return the completed form to the School Office before she will be given permission to self-administer her asthma medications on school property or at any school-sponsored activity.

I,_____, parent/guardian of the above named student, authorize Assumption High School to allow the student to carry with her and self-administer her asthma medications.

Signature:_____ Date:_____

I,_____, parent/guardian of the above named student acknowledge that Assumption High School shall incur no liability as a result of any injury sustained by the student from the self-administration of asthma medications. I agree to indemnify, hold harmless, waive and relinquish any and all claims I may have against Assumption High School and its officers, agents, employees, representatives or volunteers.

Signature:_____ Date:_____

If your daughter has asthma and she must self-administer asthma medications at school,
THE STUDENT'S PHYSICIAN MUST COMPLETE THIS SECTION AND SIGN WHERE INDICATED.

I,_____, verify that _____
Physician/Health Care Provider's Name (please print) Print Student's Name

has asthma and that the student has been instructed in self-administration of the asthma medications listed below:

Name of Asthma Medication Prescribed	Prescribed Dosage	Time(s), circumstances, any specific instructions under which medication must be administered

Signature:_____ **Date:** _____
Physician/Health Care Provider

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FOOD ALLERGY AND ANAPHYLAXIS MEDICATION AUTHORIZATION FORM 2020-2021

If your daughter has a severe food allergy or other allergy that could require the administration of emergency rescue medication, this form must be completed, signed, and returned to the School Office by **Thursday, July 30, 2020**.

STUDENT NAME: _____ STUDENT I.D. #_____
(PRINT): Last First Middle (office use only]

If your daughter has a severe allergy and may need to self-administer anaphylaxis rescue medication (epinephrine via EpiPen, Twinject, Auvi-Q, etc.) at school,

the parent and the student's health care provider must complete and sign all sections below.
You must return the completed form to the School Office before she will be given permission to self-administer her anaphylaxis rescue medication on school property or at any school-sponsored activity.

I,_____, parent/guardian of the above named student, authorize Assumption High School to allow the student to carry with her and self-administer her anaphylaxis rescue medication.

Signature:_____ Date:_____

I,_____, parent/guardian of the above named student, authorize Assumption High School personnel to administer anaphylaxis rescue medication to the student in the event the student is unable to self-administer due to the severity of the allergic reaction/anaphylaxis or not having her rescue medication with her.

Signature:_____ Date:_____

I,_____, parent/guardian of the above named student acknowledge that Assumption High School shall incur no liability as a result of any injury sustained by the student from the self-administration of anaphylaxis rescue medication or from Assumption High School personnel administering emergency rescue medication to her. I agree to indemnify, hold harmless, waive and relinquish any and all claims I may have against Assumption High School and its officers, agents, employees, representatives or volunteers.

Signature:_____ Date:_____

I,_____, parent/guardian of the above named student hereby give permission for the health care provider completing and signing this form (below) to verify this information with Assumption High School and consult with AHS staff regarding this information.

Signature:_____ Date:_____

If your daughter has a severe allergy and may need to self-administer anaphylaxis rescue medication at school, <u>THE STUDENT'S PHYSICIAN</u> MUST COMPLETE THIS SECTION AND SIGN WHERE INDICATED.

I,_____, verify that _____
Physician/Health Care Provider's Name (please print) Print Student's Name

is extremely reactive to the following allergens (specify) _____,

has been instructed in self-administration of her anaphylaxis rescue medication, and may carry it with her to self-administer if necessary.

In the event of mild symptoms (itchy mouth, runny nose, mild rash, etc.)., the student may self-administer or school personnel may administer

Antihistamine Brand or Generic: _____ Dose _____

In the event of severe symptoms (shortness of breath, tightness of throat, dizziness, etc.)., the student may self-administer or school personnel may administer, and 911/EMS will be called.

Epinephrine Brand or Generic: _____ Dose _____

Signature: _____ **Date:** _____
Physician/Health Care Provider

Please return completed forms to the School Office by Thursday, July 30, 2020

This page is intentionally blank.

DIABETES MEDICATION AUTHORIZATION FORM 2020-2021

If your daughter has diabetes, this form must be completed and returned to the school office no later than **Thursday, July 30, 2020.**

Student Name: _____ Student I.D.# _____
(please print): Last First Middle (office use only)

If your daughter has Diabetes
but <u>does NOT</u> want to monitor her glucose level by herself or to self-administer her diabetes medication,

complete and sign only this section of the form and return it to the School Office.

I, _____parent/guardian of the above named student, verify that my daughter has Diabetes, but does not want at this time to monitor her glucose level by herself or self-administer her diabetes medication at school, at school-sponsored activities, or any time she is present on Assumption High School's property.

Signature: _____ **Date:**_____

If your daughter has Diabetes
and wants to monitor her glucose level by herself and self-administer her diabetes medication at school,

the parent and the student's physician must complete and sign all sections below.
You and your daughter will then meet with the school nurse and/or the Dean of Students
to ascertain her health condition and ability to self-administer her medications.

I,_____, parent/guardian of the above named student, authorize Assumption High School to allow her to carry with her a meter to read her glucose level as well as her diabetes medication.

Signature: _____ **Date:**_____

I,_____, parent/guardian of the above named student, acknowledge that Assumption High School shall incur no liability as a result of any injury sustained by the student to herself from monitoring her glucose level or self-administration of diabetes medication or as a result of any injury inflicted on others while monitoring her glucose level or self-administering the diabetes medication. I agree to indemnify, hold harmless, waive and relinquish any and all claims I may have against Assumption High School and its officers, agents, employees, representatives, or volunteers.

Signature: _____ **Date:** _____

THE STUDENT'S PHYSICIAN MUST COMPLETE THE FOLLOWING SECTION AND SIGN WHERE INDICATED.

I, _____, verify that _____
Physician/Health Care Provider's Name (please print) Print Student's Name

has Diabetes and the student has been instructed in self-administration of the diabetes medications listed below.

NAME OF MEDICATION **PRESCRIBED DOSAGE**

_____

_____

_____

Signature: _____ **Date:**_____
Physician/Health Care Provider