CBC High School
1850 De La Salle Drive
St. Louis, MO 63141

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Health Forms

PHYSICALS

1. ***A school physical and current immunization record*** are required of all incoming freshmen and transfer students. Physical must be performed after February 1, 2019 for the upcoming school year. **DUE: July 1st.** If playing a sport, the MSHSAA Sports Physical form may be used for physical exam instead of the CBC physical exam form.
2. A ***MSHSAA health history, physical exam, and consents*** (4 pages) are required of all students who plan to participate in a sport. Physical must be performed after February 1, 2019 for the upcoming school year. **DUE: July 1st.** Please follow the link to the required packet. https://www.mshsaa.org/resources/pdf/PreParticipationPhysicalEvaluation_1617.pdf

STUDENTS MAY NOT TRY OUT FOR A SPORT OR ATTTEND ORIENTATION WITHOUT REQUIRED PAPERWORK ON FILE IN THE NURSE'S OFFICE.

MEDICATION

3. ***Medication Permission*** **-** Tylenol, Advil and Tums are available in the nurse's office. These medications may be administered by the school nurse if form is on file. If student requires other over-the-counter medication, the Over the Counter Medication section must be completed in full and the medication must be supplied by the family. **Renewed annually.**

4. ***Prescription Medicine / EpiPen Release*** **-** If student is on a prescription medication and is to receive the medication at school, the Prescription Medicine Release section must be completed in full and **signed by a physician.** It is the student's responsibility to report to the nurse's office for administration of medication. **Renewed annually.**

   Students with an allergy history requiring an EpiPen must have a dose of this emergency medication in the nurse's office. This medication may also be carried by the student. The *Prescription Medicine /EpiPen Release portion* must be completed in full, **signed by a physician**, with an allergy action plan included. **Renewed annually.**

5. ***For Inhaler Use Only*** **-** If student uses an inhaler, this form must be completed in full, signed by a physician, with an asthma action plan included. **Renewed annually.**

- Medications may not be carried by students at any time. Inhalers, EpiPen, and insulin are the ***only*** exceptions.
- Medication should be in the original container labeled clearly with student's name.
- A physician's signature is required before prescription medication can be administered.
- Medication not claimed by June 1st will be discarded.

Christian Brothers College High School
PHYSICAL EXAMINATION FORM FOR NEW STUDENTS

Complete this form only if your son will not be playing a sport.

TO BE COMPLETED BY PARENT

Name

Address

Grade

Date of Birth

Parent/Guardian (Please print)

HISTORY

ADHD Yes ____ No ____

Allergies (list)

Epinephrine prescribed
Yes ____ No ____

Asthma
Yes ____ No ____

Diabetes
Yes ____ No ____

Epilepsy
Yes ____ No ____

Other Serious Illness

Has child ever been advised to restrict activity in the last five years?

Surgeries

Medications

Parent Signature / Date

PHYSICAL
TO BE COMPLETED BY EXAMINER

Is student under care at this time?

PHYSICAL FINDINGS

Height **Weight**

B/P **Pulse**

Eyes: **L** **Both**

R

Cover Test

Hearing Test:

Hearing Screening

	500	1000	2000	4000
Right				
Left				

ENT

Chest/Lungs

Heart

Abdomen

Hernia

Lymph Nodes **Genitalia**

Neurologic **Scoliosis**

Urinalysis (as needed)

Sugar _____ **Albumin** _____

ORTHOPEDIC EXAM (for PE/Intramurals)

ROM

Back

Neck/shoulders

Upper Extremities/Arm/Hand

Lower Extremities/Hip/Leg/Foot

Head Injury

Other serious injury

TO BE COMPLETED BY EXAMINER
RECOMMENDATION FOR SCHOOL

Special Seating Recommended:

Medical Treatment at School

RECOMMENDATIONS (for PE/Intramurals)

Full unlimited participation

No participation

Limited participation

Clearance withheld until:

Signature of Examiner

Name of Examiner (Please print)

Address

Phone ( )

DATE OF EXAM

IMMUNIZATIONS

Please attach immunization record to this form.

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Prescription Medicine / EpiPen Release

Fill out regardless if taken at home or school.

Student: _____ FR SO JR SR
(circle one)

ALLERGIES: _____

CHRONIC HEALTH CONDITIONS: _____

Name of medication _____
Reason prescribed_____
Dose _____Route _____
Frequency of administration _____
Administered at school _____ home _____
Duration of administration _____

Name of medication _____
Reason prescribed_____
Dose _____Route _____
Frequency of administration _____
Administered at school _____ home _____
Duration of administration _____

Name of medication _____
Reason prescribed_____
Dose _____Route _____
Frequency of administration _____
Administered at school _____ home _____
Duration of administration _____

_____ _____ _____ _____
Physician's Signature **Date** **Parent Signature** **Date**

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FOR INHALER USE ONLY

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION
WAIVER/INDEMNIFICATION FROM LIABILITY

The undersigned parent/guardian ("Parents") hereby authorize CBC High School to allow the Parents' child named below ("Child") to self-administer the medications(s), and represent to CBC High School that the history stated below of the child's experience with the illness being treated by the Medication is accurate and complete. The Parents also authorize CBC High School to implement the plan of action stated below for addressing any emergency situation which may arise as a consequence of the Child self-administering the medication.

The School hereby notifies the Parents that neither the School, its employees nor its agents shall incur any liability as a result of any injury arising from the self-administration of the Medication by the Child, and the Parents hereby acknowledge that no such liability shall exist, and on behalf of themselves and the Child hereby waive any such liability. Furthermore, the Parents hereby agree to indemnify and hold the School, its employees and its agents harmless against any claims whatsoever arising out of the self-administration of the Medication by the Child.

Name of Child _____ Fr. Soph. Jr. Sr.
(Circle one)

Medications(s) _____

Medical History _____
_____

Emergency Plan of Action _____
_____

For School Year _____

Signatures:

Parent/Guardian: _____ Date: _____

Physician signature with permission for child to self-administer above named medication(s) must accompany this form:

Physician: _____ Date: _____

THIS FORM MUST BE RENEWED ANNUALLY

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Student: _____ FR SO JR SR
(circle one)

ALLERGIES: _____

CHRONIC HEALTH CONDITIONS: _____

Medication Permission
Required for Tylenol/Advil/Tums

Tylenol (acetaminophen) **YES** **NO**
(500 mg or 1000 mg - based on student's weight) 1 dose maximum

Advil/Motrin (ibuprofen) **YES** **NO**
(400 mg) To be given every 6 hours, 2 doses maximum

Tums/Rolaids **YES** **NO**
(2 tablets) 1 dose maximum

Claritin (Loratadine) **YES** **NO**
(10 mg) 1 dose maximum as needed for allergy symptoms

Gas X **YES** **NO**
(1-2 capsules as needed for gas)

Parent Signature_____ Date _____

Over the Counter Medicine Release
Fill out only if taken at school.

Name of medication _____
Dose_____ Route _____
Frequency of administration_____
Duration of administration _____

Parent Signature_____ Date _____