SANDIA PREP

DUE JULY 16, 2018

MEDICAL HISTORY QUESTIONNAIRE (2018-2019)

Student Name ____ Date of Birth ______________________ Age__________
Gender _______ Entering Grade ________ Main contact name and number ____
Insurance Company Name ________________________________ Member or Group Number _________________________
Parent Name___________________________________ Relationship ________________ Contact # __________________
Parent Name___________________________________ Relationship ________________ Contact # __________________
Other Emergency Contact Name______________________ Relationship ________________ Contact # __________________

Medical Alerts (i.e.,asthma): ____
Specific name of medications currently taking (i.e., inhaler type /epi-pen): ____
Allergies (i.e., Bees/nuts/latex/oils): ____

Have you ever had or been diagnosed with the following? (circle yes/no, specify below if necessary)

1. Yes No Anemia
2. Yes No Headaches/Migraines
3. Yes No Asthma/Exercise Induced Asthma
4. Yes No Heat Illness/heat cramps
5. Yes No Bee sting reaction
6. Yes No High Blood Pressure
7. Yes No Diabetes
8. Yes No Mono/Hepatitis (in last year)
9. Yes No Epilepsy/Seizure disorder
10. Yes No Skin problems

11. Yes No Have you ever had a concussion or head injury?
12. Yes No Are you missing any organs (i.e., kidney, eye, testicle)?
13. Yes No Do you wear contacts/glasses? Do you wear protective eyewear?
14. Yes No Have you had any surgeries?
15. Yes No Have you had any fractures (including stress fractures)?
16. Yes No Have you had any joint related injuries (dislocations, subluxations, etc.) that have limited your activity level?
17. Yes No Have you had any soft tissue injuries (sprains or strains) that have limited your activity level?
18. Yes No Do you have any metal implants (plates, screws, pins, wires) in your body?
19. Yes No Have you had an injury to the back or neck
20. Yes No Have you ever had numbness or tingling in the arms or legs?
21. Yes No Have you ever become dizzy or passed out during or after exercise?
22. Yes No Do you experience extreme fatigue or get more tired than your friends with exercise?
23. Yes No Have you ever experience syncope/fainting with or without activity?
24. Yes No History of sickle cell, Marfan's syndrome, Long QT syndrome, or heart arrhythmias in your family?
25. Yes No Do you have any heart problems or had an EKG/ECG?

Please explain any "Yes" answers (indicate the question # you are explaining).

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PERMISSION TO RECEIVE OVER THE COUNTER MEDICATION

My child has permission to receive the following over the counter medications per package directions for routine complaints following an evaluation by SPS School Nurse/Athletic Trainer.

Please put a check on the line next to the medication(s) your child may receive. Sign your name and place the date. Meds will not be given without this information filled out and approved.

________ Tylenol/Acetaminophen headache/cold/flu symptoms
________ Motrin/Ibuprofen for minor inflammation, pain or fever
________ Tums for upset stomach
________ Benadryl for allergic reactions
________ Midol for menstrual cramps (female only)
________ Visine allergy relief for eye irritation
________ Throat lozenges for sore throat
________ Essential oils

Parent Signature ____ Date ____________________

Parent Signature ____ Date ____________________

CONSENT TO PARTICIPATE IN SPS ACTIVITIES

This consent allows my child to participate in any and all activities sponsored by Sandia Prep School. When a child participates in any physical activity, there is a risk of injury. Competition or participation in any physical activity may result in injuries or illnesses, which may be serious, permanent, or fatal. Those activities of a collision nature may result in injury to a greater extent than those incurred via non-contact sports. This consent allows my child to be administered first aid by the staff at Sandia Prep School. If an emergency should arise, and parents/guardian/emergency contact is unavailable, Sandia Preparatory School personnel are designated to authorize medical attention and hospitalization. A practicing physician or medical personnel will then act in the best interest of the child. Parents will be financially responsible for services rendered. The provided emergency information will be shared with/distributed to coaches, faculty members and sponsors as needed. I/we have read the above statements, including the risks taken with participation, and agree to allow my/our child to participate in all school-sponsored activities. Exceptions should accompany this form.

Parent Signature ____ Date ____________________

Parent Signature ____ Date ____________________

PRIVACY STATEMENT AND CONSENT

Please be aware that although we maintain compliance with HIPAA and FERPA laws, SPS will share health information regarding your child with others such as faculty members, teachers, OLP staff, and coaches when necessary in order to provide safety to your child in all circumstances. "I consent to allow any/all healthcare providers at SPS to share any information about my child deemed necessary for participation in any school-related activity".

Parent Signature ____ Date ____________________

Parent Signature ____ Date ____________________

MEDICAL EVALUATION
EVALUATION MUST BE PERFORMED AFTER APRIL 1, 2018

Name ____________________________________ DOB _____________ Date of Evaluation ______________

Height ________________________ Weight _____________________________ Temperature _____________

Heart Rate ______________ Respirations __________________ Blood Pressure ______________________

Visual Acuity: R20/_________ L20/________ Corrected: Y/N Pupils: equal __________ not equal _________

Medical Exam (**N=Normal A=Abnormal N/A = not applicable, not tested**)

Eyes/Ears/Nose/Throat _____ Hearing _____ Lymph Nodes_______

Heart (supine and standing) _______ Heart murmur (yes or no) _________

Lungs: auscultation ________ Skin ________ Abdomen (liver, spleen) __________

Genitourinary (males) ______

Musculoskeletal Exam (N=Normal A=Abnormal L=Laxity)

General Posture ____ Neck _______ Back _______

Shoulders/Arms _____ Elbows/Forearms _________ Wrist/Hands/Fingers _______

Hips/thighs ________ Knees ______ Ankles/Feet/Toes _________

Comments ____

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PHYSICAL ACTIVITY CLEARANCE INFORMATION

Student **MAY** participate in the following types of activities:

All forms of sports ____________
Non-contact sports ____________
Limited activity ____________

NOT cleared for the following ____

Physician's Printed Name ____ Date ___________________

Licensed Physician's Signature ____