Clinic Information and PE Clearance Form

Student's Name ____ D.O.B. ____________________

Student's Grade Level for 2019-2020: (circle)

1 2 3 4 5

The over the counter medications listed below may be given to students on an as needed basis. All medications will be given at the weight appropriate doses recommended by the manufacturer. Please place an "X" over any medications you DO NOT want you child to have.

Hydrocortisone Cream Tylenol Ibuprofen TUMS Cough Drops

My child, as listed above, has my permission to participate in physical education and all other activities deemed appropriate and directed by Notre Dame Academy faculty/staff. I understand that all precautions will be taken to ensure the safety of the students. I also recognize that there are inherent risks involved in certain activities. Understanding that my child may need emergency medical treatment during school hours or at school activities while he/she attends NDA, I authorize the School, through its nurse or other qualified person, to administer such first aid or other medical treatment, including over the counter medications, as shall be deemed best under the circumstances. I consent for my child to receive such treatment. I understand that the School will attempt to notify parents in the event of an emergency requiring immediate medical care for my child. If school personnel are unable to notify parents, they will have my child treated by a duly qualified physician at the nearest appropriate emergency hospital or clinic. To ensure the care of my child, I agree that pertinent health information must be provided to, and shared with appropriate school staff. I agree to alert the school nurse and my child's teacher of any change in medications and/or health status of my child. I will furnish the school with a current telephone number and address in case of an emergency.

I will personally deliver any prescription medications to the school nurse and complete the medication administration permission form.

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Parent Signature

Emergency Contact 1 (other than parents)____

Emergency Contact Phone ______________________________Cell___________________________

Home Phone ____

Mother Cell ____________________________ Mother Work # ____________________________

Father Cell _______________________ Father Work #_________________________________

Student's Physician: ______________________________________ Phone: ___________________

Student's Dentist: ____ Phone: ___________________

Please see other side

Name ____________________________**Weight** _____________**D.O.B.** _____________**Grade**_______________

Parents, please answer the following questions about your child's health:
Has this child ever had any of the following? (Circle Y for yes, N for no)

Allergies: Bee, Wasp or fireant	Y	N	Frequent headaches/migraines	Y	N	ADD/ADHD	Y	N
Allergies: Food	Y	N	Skin problems	Y	N	Frequent stomach aches	Y	N
Allergies: Medication	Y	N	Eczema	Y	N	Diabetes	Y	N
Asthma	Y	N	Irregular heartbeat or heart murmur	Y	N	History of Urinary Tract infections	Y	N
Inhaler: as needed or daily	Y	N	Fainting or dizziness w/excercise	Y	N	Anemia	Y	N
Epipen	Y	N	Chest pain w/exercise	Y	N	Hemophilic	Y	N
Sinus Trouble	Y	N	Shortness of breath w/exercise	Y	N	History of Seizures	Y	N
Frequent Colds	Y	N	Frequent Nosebleeds	Y	N	High/Low Blood Pressure	Y	N
Chronic cough	Y	N	Family history of sudden death before age 50	Y	N	Another condition that might affect child	Y	N

If you answered YES to any of the items above, please provide an explanation and details below:

Medical Diagnosis:____

____

Allergic to: _______________________________Reaction:___________________________________

History of Anaphylactic Reaction: Y N (circle one)____

Treatment for allergy : ____

If a child has a food or insect allergy that may require medication, an Allergy Action Plan, available in the clinic, must be filled out by the child's physician. Any emergency medications necessary must be provided to the school by the parent(s). NDA will provide an Allergy Action Plan for the parent(s) to have filled out by the physician based on the information on this sheet. Please contact the school nurse to formulate a plan for the treatment of your child's allergy that may require medication.

If Female, has your daughter started her period. Yes No If yes, when? ____________________________

Does the student take any medication? Yes No. If Yes, please indicate medication, reason for medication & dose: ___

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Is medication taken daily or as necessary? ____

____

My child is physically fit to participate in regular physical education activities at Notre Dame Academy during the 2019-2020 school year. I certify that all answers are correct. I understand that any falsification will result in the child's suspension from the school activity for which he/she is a participant. **This form is for school PE participation only. A GHSA physical form must be filled out for extra curricular sports activities. GHSA recognizes physical done on or after April 1 to be good for the entire school year.**

Parent's signature ____ **Date** ____________________