March 2017

Dear Parents and/or Guardians:
The attached form must be completed and returned to the Medical Office by Monday, August 28, 2017. On the bottom section of the medical report, the doctor must check "Full Physical Activity" to attend school, "May participate in…" to participate in sports, and "May have working papers" to participate in the internship program.

THE NO SHOTS SCHOOL POLICY allows for no exceptions.
Any forms using <u>whiteout</u> will not be accepted.

Note that new students entering Bishop Kearney from outside the United States must have a medical done in New York State and evidence of a PPD (Mantoux) test for TB. Please remember to return to the doctor so her arm can be checked and the results noted.

ANSWERS TO FREQUENTLY ASKED QUESTIONS:

What if my insurance only covers one physical per year? If your insurance coverage does not allow for a new physical exam until a year from the last one, please have your physician fill out the form based on her last exam. The date of that exam should be on the form. You will then have to return for your daughter's yearly exam and have a new form filled out.

Is there anything I need to know about filling out the medical form? Please be sure to check that the physician has answered all questions to avoid having to return to have the form completed. The doctor must check full "physical activity" and may participate in interscholastic sports, for gym and sports.

My doctor uses his/her own form. Can I send that instead of the Bishop Kearney form? If the physician wishes to use his/her own form, he/she may, but must complete the bottom of our form with his/her signature and stamp. Parent/Guardian must complete the front of the form. Both forms must be attached with the student's name and returned to the Medical Room at Bishop Kearney by **August 28, 2017.**

If you have any further questions please contact the Office of Admissions at 718-236-6363 ext 255.

Sincerely,

Rachel Kasold
Director of Admissions

MEDICAL HISTORY AND REPORT FORM

(TO BE COMPLETED BY THE PARENT/GUARDIAN)

Last Name First Middle Date of Birth Male ___ Female ___

Name of Parent/Guardian (Last) First Relationship to Child

Address Borough Zip Code Apt. or Floor #

Grade/Class Language Spoken at Home Telephone Number
Home
Cell
Work

Family Medical/Hospital Insurance Carrier Policy or Group #

Please circle S to indicate student or F to indicate a family history of any conditions, past or present. Please provide details below (attach any pertinent information).

Allergies/Hay Fevers	S	F	Hearing	S	F
Insect/Sting Allergy	S	F	Heart Murmur/Rheumatic Fever/Heart Disease	S	F
OD/ADHD	S	F	Hepatitis	S	F
Anemia/Sickle Cell	S	F	Hernia	S	F
Arthritis	S	F	Lead	S	F
Asthma (give details below)	S	F	Lung Disease/TB	S	F
Back/Neck Injury or conditions	S	F	Measles	S	F
Bladder Kidney Problems	S	F	Medication Reaction	S	F
Blood Clotting Disorder	S	F	Mononucleosis	S	F
Cancer/Leukemia	S	F	Orthopedic Bones	S	F
Chickenpox	S	F	Psychological/Psychiatric	S	F
Seizures/Epilepsy/Convulsions	S	F	Surgery	S	F
Diabetes	S	F	Speech	S	F
Head Injury/Concussion	S	F	Vision	S	F
Headaches	S	F	Other (explain below)	S	F

Please give details for all CIRCLED:_____

_____

_____

Is the student under any medical care or treatment? Yes ____ No ____ Explain _____

_____

Does the student take any medications (prescribed and/or OTC?) Yes ____ No ____
Explain _____

_____

Specifically during or after exercise has the student experienced any of the following? CIRCLE all that apply.

Fainting/Passing Out Heat Stroke Severe Lightheadedness/Dizziness
Coughing/Wheezing Extreme Shortness of Breath Excessive Bruising
Chest Pain Numbness/Tingling in _____

Was a medical evaluation done? Yes ____ No ____ Result of Exam _____

_____

Has the student ever been denied athletic participation for medical reasons? Yes __ No__
Explain _____

THIS SECTION MUST BE SIGNED TO COMPLETE MEDICAL FORM

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed school activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the school and camp to order x-rays, routine tests and treatment for any child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of school.

Signature of parent/guardian _____

Also understand and agree to abide with the restrictions placed on my school activities

Signature of minor _____

ENTRY INTO BISHOP KEARNEY HIGH SCHOOL IS PROHIBITED BY LAW UNLESS THIS CERTIFICATE IS ON FILE.

MEDICAL REPORT
(TO BE COMPLETED BY PHYSICIAN)

STUDENT'S LAST NAME FIRST NAME MIDDLE INITIAL

_____

IMMUNIZATION HISTORY

VACCINE TYPE	DATES OF VACCINATIONS				
Tdap Booster	_____	_____	_____	_____	_____
DPT, DT, or Td	_____	_____	_____	_____	_____
Pollo: TOPV	_____	_____	_____	_____	_____
IPV (SALK)	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Hepatitis B/Varicella	_____	_____	_____	_____	_____
Meningococcal	_____	_____	_____	_____	_____

Does the student have a past or present medical history of the following?

Pres.	Past	No		Pres.	Past	No		Date	Details
□	□	□	ASTHMA (If present, attach medication form)	□	□	□	Diabetes (If present, attach medication form)	_____	
□	□	□	Allergies	□	□	□	Cancer	_____	
□	□	□	Congenital Heart Disease	□	□	□	Orthopedic Problems	_____	
□	□	□	Seizures	□	□	□	Hearing Problems	_____	
□	□	□	Vision Problems	□	□	□	Speech Problems	_____	
□	□	□	Hospitalizations	□	□	□	Serious Illness	_____	
□	□	□	Surgery	□	□	□	Serious Accidents	_____	
□	□	□	Other Problems/ Limitations					_____	

PHYSICAL EXAMINATION: Height _____in(__%ile) Weight _____lb (__%ile) BMI _____ (__%ile) Blood Pressure ____/____

GENERAL APPEARANCE (Nutritional Status): _____

NL	AB		NL	AB		NL	AB		NL	AB	
□	□	HEENT	□	□	ABDOMEN	□	□	NEURO	□	□	FINE MOTOR
□	□	DENTAL STATUS	□	□	GENITO URINARY	□	□	GROSS MOTOR			
□	□	NECK	□	□	EXTREMITIES	□	□	PSYCHO/SOCIAL DEV.			
□	□	LYMPH NODES	□	□	BACK	□	□	LANGUAGE			
□	□	CARDIOVASCULAR	□	□	SKIN	□	□	BEHAVIORAL			

DESCRIBE ABNORMALITIES:

Hearing	DATE	RESULTS	Vision				
AUDIO/SWEEP	_____	P F		FAR	NEAR		
			RIGHT	□□/□□	□□/□□	FUSION P F	
THRESHOLD	_____	P F	LEFT	□□/□□	□□/□□	COLOR P F	
			BOTH	□□/□□	□□ /□□		

Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test.

TB: Only required for student newly entering the NYC school system in Intermediate/Middle/Junior or High School.

_____

Mantoux	DATE	RESULTS
(PPD) IMPLANTED	_____	□ NEGATIVE _____
READ	_____	□ POSITIVE _____

	Chest X-Ray	BCG	On INH
DATE	_____/_____/_____	_____/_____/_____	_____/_____/_____
RESULTS	□ NORMAL □ ABMORMAL	□ YES □ NO	□ YES □ NO

DIAGNOSES- If Asthma, Indicate severity

☐ Well Child V202 ICD CODE

1. _____ ☐☐☐☐☐
2. _____ ☐☐☐☐☐
3. _____ ☐☐☐☐☐

☐ NOT INDICATED

SCREENING

Hemoglobin_____ Hematocrit _____

RECOMMENDATIONS FOR PHYSICAL ACTIVITY IN SCHOOL (CHECK ALL THAT APPLY)

_____ FULL PHYSICAL ACTIVITY
_____ MAY PARTICIPATE IN INTERSCHOLASTIC/COMPETITIVE SPORTS
_____ MODIFIED PHYSICAL ACTIVITY (SPECIFY)_____
_____ SPECIFY PHYSICAL ACTIVITY CONTRAINDICTED _____
_____
_____ MAY HAVE WORKING PAPERS

_____
SIGNATURE OF PHYSICIAN DATE OF EXAM

PRINT OR TYPE NAME OF PHYSICIAN

_____
ADDRESS BOROUGH ZIP TELEPHONE NO.

_____
PHYSICIAN'S STAMP