

**BAY RIDGE PREPARATORY SCHOOL 2010 – 2011 MEDICAL INFORMATION**

Dear Families,

As we prepare for another exciting and successful year at Bay Ridge Prep, we would like ensure the health and safety of all students who are attending our school. To that end, we are now requiring ALL STUDENTS to have this comprehensive physical exam updated yearly and submitted to us prior to the start of each school year. This form will provide us information on any allergies or special medical conditions the student has. It also covers the student's participation in physical education as well as any extra-curricular and/or athletic activities they choose to join. In order for any student to take medication during school hours or school events, the attached medication administration form must be completed.

Parents/guardians should complete the Health History Questionnaire (Part A) and must have it reviewed by the examining health care provider. The examining health care provider must complete the Physical Evaluation Form (Part B) in full.

We ask that you return this form no later than July 30 in order to make the start of school as smooth as possible for everyone. Students who do not have this form on file prior to the start of the school session may not begin attending classes. If you have any questions, please do not hesitate to contact us.

We wish you a safe, happy and healthy summer.

Wendy Freeburn, R.N.  
Admissions Coordinator; School Nurse  
wfreeburn@bayridgeprep.org

Tony Campbell  
Director of Athletics  
tcampbell@bayridgeprep.org

# BAY RIDGE PREPARATORY SCHOOL

**MEDICAL POLICIES AND PROCEDURES**

**2010 – 2011**

## Yearly Exam & Dental Record Requirement

Please be advised that, as of 2008, all students must have dental records on file with the school. Please include a copy of your child's most recent dental screening results when returning your health forms.

All students must have a yearly physical exam form on file with the school. Students may not attend school or participate in physical education and/or athletic activities without this form on file. **Please make sure to bring the enclosed Physical Examination Form with you to your child's yearly-check up.**

## Student Illness Policy

Any child complaining of illness during the school day will be evaluated by the school nurse who will then inform a parent/guardian.

- Any child who has a fever (temperature of 100.3 °F or over), nausea or vomiting must be sent home.
- Any child who exhibits signs or symptoms of a communicable disease must be sent home.
- Any child who is unable to participate in school activities due to illness must be sent home.
- Please have an alternative plan of care for your child in case of illness, as we cannot care for a sick child during the school day.
- Students must be free from fever, nausea, and vomiting for a minimum of 24 hours prior to returning to school. If your child returns to school the day after being sent home with a fever, they will not be permitted to attend.

While we understand that a child's illness can be extremely inconvenient since so many families do not have a stay-at-home parent, every parent must understand that one sick child can cause many other student and faculty illnesses. **It is very important that every family have a plan in place for child care in case your child cannot attend school.**

## Trips

Please remember that the 5<sup>th</sup> through 8<sup>th</sup> grade classes will be taking an overnight trip during the school year. Any medication your child would normally take before and/or after school will have to be given to him/her during this trip. We require the medication authorization form to be filled out for these trips. We highly recommend that you have the form completed and include any medication not normally taken during school.

## Injuries

Any student who sustains injuries during school hours will be evaluated by the School Nurse. The nurse will inform the student's parent/guardian(s) as necessary either by phone, e-mail or a letter. If the nurse feels a student needs immediate medical attention, she will inform a parent (if time permits) and 911 will be called for transport to an area hospital. Every attempt will be made to go to the hospital of the parent's choice but, in case of a true emergency, this may not be possible.

**BAY RIDGE PREPARATORY SCHOOL 2010 – 2011 PHYSICAL EXAM**

**Part A: HEALTH HISTORY QUESTIONNAIRE**

**TO BE FILLED OUT BY THE PARENT**

Today's Date: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

**Directions:** Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

**1. Have you ever had, or do you currently have:**

- a. Restriction from sports for a health related problem? Y / N / Don't Know
- b. An injury or illness since your last exam? Y / N / Don't Know
- c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
  - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
- d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
- e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
- f. Any **allergies** to medications? **Y / N / Don't Know**
- g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
  - (1.) If yes, check type of reaction:
    - Rash  Hives  Breathing or other anaphylactic reaction
    - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
- h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
- i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List all medications here:**

Medication Name	Dosage	Frequency

**\*\*PLEASE NOTE THAT ANY MEDICATION THAT NEEDS TO BE ADMINISTERED DURING SCHOOL HOURS AND/OR DURING SCHOOL EVENTS SUCH AS OVERNIGHT TRIPS MUST HAVE A SEPARATE MEDICATION ADMINISTRATION FORM COMPLETED BY YOUR HEALTH CARE PROVIDER. THAT FORM IS ATTACHED TO THE END OF THIS DOCUMENT.**

2. Have you ever had, or do you currently have, any of the following *head-related* conditions:

- a. Concussion or head injury (including "bell rung" or a "ding")? Y / N / Don't Know
- b. Memory loss? Y / N / Don't Know
- c. Knocked out? Y / N / Don't Know
- c. A seizure? Y / N / Don't Know
- d. Frequent or severe headaches (With or without exercise)? Y / N / Don't Know
- e. Fuzzy or blurry vision Y / N / Don't Know
- f. Sensitivity to light/noise Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

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3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:

- a. Restriction from sports for heart problems? Y / N / Don't Know
- b. Chest pain or discomfort? Y / N / Don't Know
- c. Heart murmur? Y / N / Don't Know
- d. High blood pressure? Y / N / Don't Know
- e. Elevated cholesterol level? Y / N / Don't Know
- f. Heart infection? Y / N / Don't Know
- g. Dizziness or passing out during or after exercise without known cause? Y / N / Don't Know
- h. Has a provider ever ordered a heart test ( EKG, echocardiogram, stress test, Holter monitor)? Y / N / Don't Know
- i. Racing or skipped heartbeats? Y / N / Don't Know
- j. Unexplained difficulty breathing or fatigue during exercise? Y / N / Don't Know
- k. Any family member (blood relative):
  - (1.) Under age 50 with a heart condition? Y / N / Don't Know
  - (2.) With Marfan Syndrome? Y / N / Don't Know
  - (3.) Died of a heart problem before age 50? If yes, at what age? \_\_\_\_\_ Y / N / Don't Know
  - (4.) Died with no known reason? Y / N / Don't Know
  - (5.) Died while exercising? If yes, was it during or after? (Circle one.) Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

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4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:

- a. Vision problems? Y / N / Don't Know
  - (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) Y / N / Don't Know
- b. Hearing loss or problems? Y / N / Don't Know
  - (1.) Wear hearing aides or implants? Y / N / Don't Know
- c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know
- d. Wear braces, retainer or protective mouth gear? Y / N / Don't Know
- e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

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5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:

- a. Numbness, a "burner", "stinger" or pinched nerve? Y / N / Don't Know
- b. A sprain? Y / N / Don't Know
- c. A strain? Y / N / Don't Know
- d. Swelling or pain in muscles, tendons, bones or joints? Y / N / Don't Know
- e. Dislocated joint(s)? Y / N / Don't Know
- f. Upper or lower back pain? Y / N / Don't Know
- g. Fracture(s), stress fracture(s), or broken bone(s)? Y / N / Don't Know
- h. Do you wear any protective braces or equipment? Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):

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6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- a. Difficulty breathing?
  - (1.) During exercise? Y / N / Don't Know
  - (2.) After running one mile? Y / N / Don't Know
  - (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
  - (4.) Exercise-induced asthma? Y / N / Don't Know
    - i. Controlled with medication? (specify \_\_\_\_\_) Y / N / Don't Know
    - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
- b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
- c. Become tired more quickly than others? Y / N / Don't Know
- d. Any of the following skin conditions:
  - (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
  - (2.) Sun sensitivity? Y / N / Don't Know
- e. Weight gain/loss (of 10 pounds or more)? Y / N / Don't Know
  - (1.) Do you want to weigh more or less than you do now? Y / N / Don't Know
- f. Ever had feelings of depression? Y / N / Don't Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
  - (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
  - (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
  - (3.) Muscle cramps? Y / N / Don't Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

\_\_\_\_\_  
\_\_\_\_\_

7. Females only:

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_

How many periods missed in the last twelve (12) months? \_\_\_\_\_

8. Males only:

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
Signature, Parent/Guardian or Student Age 18

\_\_\_\_\_  
Date of Signature

**THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**

Student's Name \_\_\_\_\_

# ANNUAL PHYS. ED & ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Exam Form

(Completed IN FULL by the examining licensed health care provider)

### -STUDENT INFORMATION-

Student's Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Parent/Guardian's Full Name: \_\_\_\_\_

### - EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

### - SCREENING TESTS & IMMUNIZATION HISTORY -

	Date Done	Results
<b>Tuberculosis</b> <small>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</small>		
PPD/Mantoux placed	___/___/___	Induration ___mm
PPD/Mantoux read	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
Interferon Test	___/___/___	<input type="checkbox"/> Neg <input type="checkbox"/> Pos
Chest x-ray <small>(if PPD or Interferon positive)</small>	___/___/___	<input type="checkbox"/> NI <input type="checkbox"/> Not <input type="checkbox"/> Abnl Indicated

IMMUNIZATIONS – DATES	CIR Number of Child						
Hep B ___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
PCV ___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio ___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Influenza \_\_\_/\_\_\_/\_\_\_

MMR \_\_\_/\_\_\_/\_\_\_

Varicella \_\_\_/\_\_\_/\_\_\_

Td \_\_\_/\_\_\_/\_\_\_

Tdap \_\_\_/\_\_\_/\_\_\_ Hep A \_\_\_/\_\_\_/\_\_\_

Meningococcal \_\_\_/\_\_\_/\_\_\_

HPV \_\_\_/\_\_\_/\_\_\_

Other, specify: \_\_\_\_\_; \_\_\_\_\_

**- FINDINGS OF PHYSICAL EVALUATION -**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	CIRCLE IF NORMAL	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
Previous Syncopal Episode	ABSENT	
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

**Most recent immunizations and dates administered:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications currently prescribed, with dose and frequency:**

Medication Name	Dosage	Frequency

**\*\*Dear Health Care Provider:** Please complete the Medical Administration Form for any medication that the student may have to take during school hours and/or during school events such as overnight trips. We recommend that you consider as antipyretic and/or analgesic in case the student needs it during school.

*Student's Name* \_\_\_\_\_

**Additional observations:**

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**General Diagnosis:** \_\_\_\_\_

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**General Recommendations:**

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**THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY  
THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.**

Student's Name \_\_\_\_\_

**CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)**

- A. Student is cleared for participation in **all** physical education and athletic activities without restriction.
- B. Student is cleared to participate in physical education during school hours only.
- C. Student is withheld clearance for participation in any sport until evaluation / treatment of:  
\_\_\_\_\_  
\_\_\_\_\_
- D. Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)
  - \_\_\_ CONTACT/COLLISION
  - \_\_\_ LIMITED CONTACT
  - \_\_\_ NON-CONTACT/STRENUOUS
  - \_\_\_ NON-CONTACT/NON-STRENUOUS

Due to: \_\_\_\_\_

**HISTORY REVIEWED AND STUDENT EXAMINED BY:**

**Physician's/Provider's Stamp:**

Primary Care Provider   
 License Type:  
     MD/DO   
     APN   
     PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Date of Exam: \_\_\_\_\_

**HISTORY REVIEWED BY:**

Name \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_ Review Date: \_\_\_\_\_

**NOTES TO THE EXAMINING PROVIDER**

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		<u>Strenuous</u>	<u>Non-strenuous</u>
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

# BAY RIDGE PREPARATORY SCHOOL

## **ABOUT THE MEDICATION ADMINISTRATION FORM**

**For Providers:** This form must be completed on a yearly basis by a licensed health care provider for **any** medication a student takes during school. This includes over the counter preparations and medications the student may carry and take without supervision. We find it helpful to have this form completed with any daily medication the student is taking, whether normally taken at school or not, and for any prn medication such as Tylenol for pain and fever. Please complete each section for every medication the student may take during school.

**For Parents:** In order to give any medication to your child during school we must have the medication administration authorization form filled out by your health care provider. This includes over the counter medication such as Tylenol. The following form must be completed by a parent/guardian. If your child may take medication unsupervised please make sure to initial the appropriate area on that form.

- This form must be completed yearly, we cannot use the medication administration form from a previous year.
- If you feel your child can carry and take his/her medication without supervision please advise him/her that they may not share their medication with another student.
- Any medication which may be taken during school must be provided by you in its original container, prescription medication must be in the packaging provided by the pharmacy.
- Keep in mind that students in grades 5 through 8 go on overnight trips and we will need this form to give medication during that time.

You may contact Wendy Freeburn via e-mail at [wfreeburn@bayridgeprep.org](mailto:wfreeburn@bayridgeprep.org).

**SEE FORM ON FOLLOWING PAGE →**

**BAY RIDGE PREP  
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF  
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ DOB \_\_\_\_\_ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy\*.

Signature(Parent or Guardian): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by physician:**

I request that my patient, as listed below, receive the following medication:

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	Dosage	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

**PLEASE CHECK ONE :**

- I deem this child to be **self directed** and is able to take the above medication without the supervision of school staff.
- I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication under the direction of a school nurse, physician, or parent.

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\* Medication must be in original pharmacy labeled container with specific orders and name of medication.  
\* Medication and refills must be brought to school by parent, guardian or responsible adult.

**Plan reviewed with parent(s)/guardian(s):**

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_