EMERGENCY MEDICAL AUTHORIZATION

John Paul II Catholic School **2015-2016 School Year**

_____ _____ _____
Student Name Grade/Home room Teacher Date of Birth

_____ _____ _____ _____
Address City State Zip Telephone

Purpose: to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot be reached.

A. Residential Parent/Guardian

Mother's Name _____ Daytime Phone Number _____ Cell_____

Father's Name _____ Daytime Phone Number _____ Cell_____

Other Name/Relationship_____ Daytime Phone Number _____

B. Name of Relative or Childcare Provider _____ _____
Name Relationship

_____ _____
Address Phone Number

********** PART I *OR* PART II MUST BE COMPLETED AND SIGNED **********

PART I MUST BE COMPLETED TO GRANT CONSENT: I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS/LOCAL HOSPITAL TO BE CALLED	
Doctor's Name	Phone Number
Dentist's Name	Phone Number
Medical Specialist	Phone Number
Local Hospital	Emergency Room Phone Number

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

*Medications taken:*_____

*Allergies and reactions:*_____

Chronic physical or behavioral problems:_____

Date _____ **Signature of Parent/Guardian** _____

Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II- REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action.

_____

_____

Date _____ **Signature of Parent/Guardian** _____

Address _____

ARCHDIOCESE OF CINCINNATI

PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 6-2006)

1. I, the lawful parent or guardian of (the "child"), give permission for my child to participate in the activity described on the Activity Information form and release from all liability and indemnify the Archbishop of Cincinnati, both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity.

2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

3a. I appoint the Archbishop or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the child.

(ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.

4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Signature of Parent or Guardian Date / /_____

Home Address City Zip _____

Parent or Guardian Phone No. (w) -- (h) _____

Emergency Contact Phone No. (w) _____(h) _____

****

Medical Information — Completed by Parent or Guardian — Please Print

Child's Name Birth date / /_____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

Medical Insurance Co. Policy No. _____

Member's Name Phone No. (h) (w) _____

Member's Birth date / / _____

Family Doctor Phone No._____

School Year 2015-2016

John Paul II Tuberculosis Screening Form for Students

In order to assure that John Paul II (JPII) is in compliance with Ohio State Law Revised Codes 3301.17 and 3301.13, as specified by Hamilton County Public Health TB Control Unit, we ask that you complete this questionnaire regarding your student.

Student Name_____Grade_____ Homeroom _____

1. Was your child born in the United States?
   - Yes (proceed to question 2)
   - No
     - Has your child been living in the United States for 5 years or less?
       - Yes
       - No
     - What is your child's country of birth?

       _____
2. Has your child traveled outside of the United States within the past year?
   - No (proceed to question 3)
   - Yes
     - To what country or countries did he/she travel?

       _____

       On what date did he/she return to the United States?

       _____

       Did he/she travel in a non-tourist capacity (such as a mission trip) for at least one week or stay with family/friends in a private residence?
       - No
       - Yes
3. Has anyone in your family been diagnosed or treated for TB within the past year?
   - No
   - Yes

Documented evidence of a TB screening must be received in no less than 60 days and no more than 90 days from the date of return from or first arrival to the USA from a high risk foreign country(as determined by the World Health Organization.) The test must be a Mantoux 5 TU PPD (skin test) or a QuantiFERON blood test. In addition, a foreign born student who has been in the USA for five years or less must provide documentation of a negative TB screening as specified above, within 90 days of enrollment at JPII.

I understand that I am responsible to notify the JPII school nurse of any planned or completed foreign travel during the current school year.

Parent/Guardian Signature_____Date_____

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

HealthCare Provider's signature	Print name	Phone
		( )
Address		Date
		/ /
City	State	ZIP

HEA 4242 8/06

Ohio School Health History

To be used for Pre-and Elementary School

School_____

Enrolled_____

Child's name	Gender □ Male □ Female	Age	Birthdate
Ethnicity □ Caucasian □ African American □ Hispanic □ Asian American □ Other			
Who is the child's legal guardian?	Who does the child live with?	Child's address	
Parent/Guardian	Parent/Guardian Address	Home phone number	

Social Service History

Mark the box if you have contact with any of the following agencies:

□ Child Protective Services if yes, Case worker's name:_____

□ Legal/Court System

□ Family Counseling Services

□ Mental Health Provider

□ Other:_____

Mark the box if you or your child receive any of the following medical assistance:

□ SSI, Disability □ Healthy Start □ Insurance (Blue Cross/Blue Shield, HMO)

□ LEAP □ Medicaid/CHIP □ Other:_____

Family History

Please list first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?
1.					
2.					
3.					
4.					
5.					

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? □ Yes □ No If yes, explain briefly.
How old was the mother when the child was born? Was the infant born: What was the infants birth weight? □ Full term □ Early □ Late ___Lbs. ___Oz.
Did the infant have any sickness or problems? □ Yes □ No

Developmental History

Please give the approximate age at which this child: Walked alone_____ Spoke in sentences_____ Toilet trained_____ Dressed Self_____
How does this child's development compare to other children, such as his or her brothers/sisters or playmates? ☐ About the same ☐ Delayed ☐ Advanced

Allergies

Please list and describe allergies or reactions.

Medications/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses & Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures.

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain.

Does your child always wear a seatbelt while riding in automobiles

☐ Yes ☐ No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle?

☐ Yes ☐ No

Behavioral History

The child is usually: ☐ Very active ☐ Normally active ☐ Rather inactive

Has your child every been violent or acted out in the following manner towards adults or children:

☐ Hitting ☐ Kicking ☐ Biting ☐ Fighting ☐ Scratching

Do you have any concern about how your child gets along with other children?

☐ Yes ☐ No If yes, explain_____

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of._____

_____

_____

_____

Is this student enrolled in special education course? ☐ Yes ☐ No

To enter school, the child must have 4 DPT; 3 Polio; 2 MMR

IMMUNIZATION shaded area required for school entry					
TYPE	**DATE MO/DAY/YR**				
DTaP DPT or DT					5th dose required if 4th dose given before age 4
DT/Td					
POLIO				Recommended. Required unless 3rd dose given before 4th B-Day.	
MMR				2nd dose required for K 2nd dose required for gr 7-12	
HEPATITIS B					
VARICELLA					
HIB (prior to age 5 only)				0-14 months; 3-4 doses 15-59 months: 1 dose	
TUBERCULIN TEST					
ROTAVIRUS (given @ 2-4-6 mo, not after 12 months)					
OTHER					

Verification completed by:_____ Date_____

Medication Information

Please describe any medications that your child takes daily and frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- ☐ Abnormal spinal curvature (Scoliosis)
- ☐ Allergies/hayfever
- ☐ Anemia
- ☐ Anaphylactic reaction
- ☐ Asthma or wheezing
- ☐ Attention deficit disorder (ADD)
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer type_____
- ☐ Chickenpox when_____
- ☐ Chronic diarrhea or constipation
- ☐ Chronic ear infections
- ☐ Concern about relation with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic skin conditions
- ☐ Emotional problems
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent sore throats
- ☐ Heart disease type_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV positive
- ☐ Hyperactivity
- ☐ Juvenile Arthritis
- ☐ Kidney disease type_____
- ☐ Measles (10 day)
- ☐ Meningitis or Encephalitis
- ☐ Mumps
- ☐ Mutism
- ☐ Near-drowning/Near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Rheumatic fever
- ☐ Seizure disorder/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Speech difficulties
- ☐ Stool soiling
- ☐ Toothaches or dental problems
- ☐ Tourette's Syndrome
- ☐ Urinary tract infections
- ☐ Wetting during the day or night