Known Drug Allergies:

The Calverton School

Student Name: _____ DOB:_____ Grade:_____

ATHLETICS:
I have, on this date, personally examined this student, reviewed the history and other data recorded on both sides of this form, and find this student physically able to compete in supervised activities listed below which are NOT CROSSED OFF:

Basketball	Lacrosse	Golf	Soccer
Tennis	Field Hockey	Cross-Country	Softball
Other _____			

Describe any limitations of diet or physical activity for this student: _____
_____
_____

Describe any significant illness, injuries, hospitalization in this student's history: _____
_____
_____

Please comment on any physical or emotional problems the nurse or instructors should be aware of regarding this student:
_____
_____

STUDENT MAY HAVE AS NEEDED THE FOLLOWING OVER THE COUNTER MEDICATIONS:
Put a check mark beside the following medications that may be administered on an as-needed basis. All medications must be given directly to the Nurse in their original unopened package. All medications are given per package dosage instructions.

____ Cough Drops	____Ibuprofen – dose _____	____Tylenol – dose _____
____ Topical Neosporin	____Topical Hydrocortisone	____Benadryl – dose _____
____Tums	____Other	

_____
Physician's Signature ***Date of Examination***

_____
Physician's Name (Typed or Printed) ***Address*** ***Phone***

_____
Parent's Signature*
I understand the possible consequences in the administration of the aforementioned medications. I hereby release, waive, discharge and hold harmless The Calverton School, its officers, director, and employees from any claims, demands, or suits for damages from any injury or complication which may result from the administration of the aforementioned medications.

Please return this and all school forms by ***August 3, 2009*** *to:*
The Calverton School, 300 Calverton School Road, Huntingtown, MD 20639 FAX: 410.535.6169

Revised 5/09

The Calverton School

Student Medical and Athletic Participation Evaluation 2009-2010

(To be completed and signed by physician)

Student Name: _____ DOB:_____ Grade:_____

PHYSICAL EXAM

	Normal	Abnormal	Description
Height			ft. in.
Weight			lbs. oz.
Blood Pressure			
Pulse Rate			
Head			
Eyes			
Ears			
Nose			
Teeth/Oral Cavity			
Neck/Throat			
Chest			
Lungs*			
Heart			
Abdomen			
Skin			
Musculoskeletal			
Neurological			
Endocrine*			
Psychiatric			
GU/GI			
Allergies*			

* A Medical Plan (Diabetic, Asthma, Allergy, Epi-Pen, and Food Allergy) is necessary and must be on file before the first day of school. Please contact Melissa King, R.N., to make an appointment to discuss your child's medical plan. She can be reached at 410-535-0216 x 114

WILL THIS STUDENT NEED TO TAKE DAILY MEDICATIONS AT SCHOOL? YES ☐ NO ☐
A separate permission form, (PMOF – Medication Administration Release and Authorization Form) signed by a physician and a parent, must accompany all prescribed daily medication. Medications must be in their original package from the pharmacy.

LABORATORY: If ordered by physician: _____

IMMUNIZATION RECORD:
All students, from Preschool to Grade 12, ***must*** have a current immunization record on file. Please record any immunizations administered in the past 12 months: _____

History of Chicken Pox? Yes_____ MMYY:_____/_____; No_____

Please continue on reverse side