XAVIER HAP 2017

30 West 16th Street New York, N.Y. 10011 (212) 924-7900 Fax (212) 924-0303

PERSONAL HEALTH HISTORY

Parent/Guardian: Please complete this side **BEFORE** submitting to your medical provider

Student_____ Home Phone_____

Insurance Co. & Policy #_____

Mother / Guardian_____ Work Phone_____Cell Phone:_____

Father / Guardian _____ Work Phone_____Cell Phone:_____

Complete the following checklist by indicating any of the following conditions, past or present. Include a separate sheet if additional detail is necessary.

	YES	NO	DATE
Allergies / Hayfever / Food			
Bee / Insect Sting Allergy			
ADD / ADHD			
Anemia (include sickle cell)			
Arthritis			
Asthma (give details below)			
Back / Neck Injury or condition			
Bladder / Kidney problems			
Blood / Clotting Disorder			
Cancer / Leukemia			
Chickenpox			
Convulsion / Seizures / Epilepsy			
Diabetes			
Diet Restrictions			
Head Injury / Concussion			
Headaches			

	YES	NO	DATE
Hearing			
Heart / Murmur / Rheumatic Fever			
Hepatitis			
Hernia			
Lead			
Lung Disease / Tuberculosis			
Measles			
Medication: Reaction/ Allergy (list below)			
Mononucleosis			
Orthopedic / Bones			
Psychological / Psychiatric			
Surgery			
Speech			
Vision			
Other: (explain below)			

Please give details for all that are marked ***YES*** above:_____

_____

_____

Is the student under any ongoing medical care or treatment? ☐ YES ☐ NO Explain_____

_____

Does the student take any medication (prescribed &/or OTC)? ☐ YES ☐ NO Explain. Include dosage, reason and frequency._____

_____

List any nutritional &/ or performance enhancing supplements used:_____

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

☐ Fainting / Passing-Out ☐ Heat Stroke ☐ *Severe* Lightheadedness / Dizziness ☐ Coughing / Wheezing ☐ Excessive Bruising

☐ *Extreme* Shortness of Breath ☐ Chest Pain ☐ Numbness / Tingling in_____ ☐ NONE APPLY

Was a Medical Evaluation done as a result of any of the above symptoms during exercise? ☐ YES ☐ NO Outcome:_____ _____

Please read the statements below. Your signature at the bottom of this page indicates that you agree to grant parental consent in the following areas. If you do not wish to give consent for one, or all, of the following, then please check the "DO NOT" box at the end of each statement.

CONSENT FOR EMERGENCY TREATMENT: In the event that I cannot be reached in an emergency, I give permission for an appropriate medical facility to evaluate my son and provide any necessary medical treatment. (Every effort is made to contact the parents or emergency contact person first.) ☐ **NO PERMISSION**

CONSENT TO SHARE INFORMATION: Xavier HS has permission to share information provided in this report with appropriate members of the educational team for use in meeting the health and educational needs of the student. This will be done only on a "need to know" basis, in a confidential manner. This would include permission for communication between the health provider and school nurse to facilitate this process. ☐ **DO NOT SHARE INFORMATION**

PERMISSION FOR OTC MEDICATION: Xavier HS has permission to administer medications. Consult your son's medical provider and **Cross out** any that should **NOT** be given. Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), Sudafed (cold / allergy), Chlor-Trimeton (cold / allergy), Benadryl (allergic reaction), Antacid (Maalox, Tums, Pepto-Bismol), Throat Lozenge, Antibiotic Ointment. ☐ **DO NOT GIVE ANY MEDICATIONS**

Parent / Guardian Signature_____ _____Date_____

Must be completed and submitted with the HAP application by April 6!

Xavier HAP Medical Report and Sports Participation Screening

TO BE COMPLETED BY HEALTH PRACTITIONER *AFTER REVIEWING REVERSE SIDE*

Student_____ DOB_____Date Exam Performed_____

PHYSICAL EXAM:

Height:_____%_____ Weight:_____%_____ Note to Seniors: **Some Christian Service sites require a PPD. Please request to** have one done now if you need one.

Pulse_____ Resp._____ B.P._____/_____

Check each line	*Normal*	Abnormal	Follow-up	Omitted
General				
Skin / Scalp				
HEENT				
Neck				
Lungs				
Heart				
Abdomen				
Musculoskeletal /Scoliosis				
Neurological				
Endocrine				
Genitalia/ Tanner Stage				
Psychosocial				
Nutrition				
Dental				

IMMUNIZATION HISTORY: Please complete, "on file" not accepted

***Minimum requirement prior to attendance**

DOSE:	1	2	3	4	5	6
DPT	*	*	*			
DPT/HIB						
DTaP						
DT/ Td				***Booster every TEN***		
OPV	*	*	*			
IPV						
MMR	*	*		TWO Measles REQUIRED		
Measles	*	*				
Mumps	*					
Rubella	*					
HIB						
Hep. B	*	*	*	***REQUIRED***		
Varicella				***Had Chickenpox Disease: YES***		

ALLERGIES:

Epi-Pen Prescribed: ☐ YES **CHECK BELOW ☐ NO

ASTHMA: ☐ YES ☐ NO ☐ Active ☐ Resolved

Age of Onset: ***Last Episode(year):***

Asthma Medications: **MDI: *CHECK BELOW*

HISTORY OF ILLNESS / SURGERY / MEDICATION:

PPD Mantoux: REQUIRED for any student NEW *to NYC schools*

Date	*Results*	X-ray

Hematocrit /Hemoglobin

Date	HCT	HGB

Vision Screening

Date	Right	Left

Auditory Screening

Date:		
Right	PASS	FAIL
Left	PASS	FAIL

*******RESTRICTIONS / INSTRUCTIONS*******

CLEARED TO PARTICIPATE IN GYM AND SPORTS: ☐ YES ☐ NO ****NOTE ANY RESTRICTIONS ABOVE****

Please check to indicate your instructions and permission.

☐ YES ☐ NO Xavier HS has permission to administer OTC medications. ***Please note and initial parental permission on reverse side of this form.

☐ YES ☐ NO ☐ N/A ASTHMA: Student may *carry and self-administer* Metered Dose Inhaler LISTED ABOVE in Asthma section.

☐ YES ☐ NO ☐ N/A EPI-PEN: Provided by student. Prescribed for anaphylaxis to a specific KNOWN allergy, listed above.

☐ YES ☐ NO EPI-PEN: Provided by the School in the event of UNKNOWN anaphylactic reaction.

Medical Provider Signature_____Date_____

OFFICE STAMP: Name /Address / Phone:

Must be completed and submitted with the HAP application by April 6!