 **Health Form**

Physical Examination: Completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant, or certified advanced registered nurse practitioner

Student’sName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_ % Body Fat: \_\_\_\_\_\_ Pulse: \_\_\_\_\_\_ Blood Pressure: \_\_\_\_ / \_\_\_\_ ( \_\_\_\_/\_\_\_\_ , \_\_\_\_ /\_\_\_\_ ) Temperature: \_\_\_\_\_\_\_Hearing: right: P \_\_\_\_\_\_ F \_\_\_\_\_ left: P \_\_\_\_\_ F \_\_\_\_\_ Visual Acuity: Right 20/\_\_\_\_\_\_\_ Left 20/\_\_\_\_\_\_\_ Corrected: Yes / No Pupils: Equal / Unequal

|  |  |  |  |
| --- | --- | --- | --- |
| FINDINGS | NORMAL  page1image57018672.png | ABNORMAL FINDINGS | INITIALS |
| MEDICAL: | | | |
| 1. Appearance |  |  |  |
| 2. Eyes/Ears/Nose/Throat |  |  |  |
| 3. Lymph Nodes |  |  |  |
| 4. Heart | page1image42173376.png |  | page1image42173376.png |
| 5. Pulses |  |  |  |
| 6. Lungs |  |  |  |
| 7. Abdomen |  |  | page1image42173376.png |
| 8. Skin |  |  |  |
| MUSCULOSKELETAL: | | | |
| 10. Neck |  |  |  |
| 11. Back | page1image42173376.png |  | page1image42173376.png |
| 12. Shoulder/Arm |  |  |  |
| 13. Elbow/Forearm |  |  |  |
| 14. Wrist/Hand |  |  | page1image42173376.png |
| 15. Hip/Thigh |  |  |  |
| 16. Knee | page1image42173376.png page1image42173376.png |  | page1image42173376.png page1image42173376.png |
| 17. Leg/Ankle |  |  |  |
| 18. Foot | page1image42173376.png |  | page1image42173376.png |

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER: I hereby certify that each examination listed above was performed by me or an individual under my direct supervision with the following conclusion(s): \_\_\_\_ Cleared without limitation \_\_\_\_ Disability:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Precautions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not cleared for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Physician** (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician/Physician Assistant/Nurse Practitioner (Signature)

Medical Release: Completed by parent (print legibly) Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

InsuranceProvider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Check all that apply: | | Details: |
| □ | Asthma | Inhaler? Y / N |
| □ | Allergies | Epi-pen? Y / N |
| □ | Diabetes |  |
| □ | Heart Condition |  |
| □ | Migraines |  |
| □ | Seizures |  |
| □ | Other |  |

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| I authorize the use of the following over-the-counter medicines by my child during band camp, rehearsals, performances, and/or competitions should it be deemed necessary: | | |
| □ | Acetaminophen –Tylenol | Headaches, muscle pain |
| □ | page1image42173376.pngAntibiotics (topical) – Neosporin  page1image42173376.png | Scrapes, cuts |
| □ | Benadryl (oral) | Allergies |
| □ | Benadryl (topical) | Bug bites, rash |
| □ | Ibuprofen –Advil, Motrin | Headaches, muscle pain |
| □ | page1image42173376.pngIntestinal Medications – Pepto, Tums | Upset stomach |

Please list all prescription and non-prescription medication(s) that is taken on a regular basis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_In the event that parents/guardians are not available, I designate the following person as an Emergency Medical Contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my permission and consent for my student to participate in all band activities, including practices, camps, home and away games, competitions, trips and other music related events throughout the year.  I furthermore, give my permission and consent for my student to be supervised by the band director, band staff and individuals delegated as chaperones at such events. I also authorize the band director, staff and any chaperones delegated to obtain, through any licensed medical personnel/physician of their choosing, any medical care that they deem reasonably necessary should my child be injured or become seriously ill during any and all functions. I hereby grant permission to the licensed hospital and/or health center staff members to administer immediate medical treatment as deemed necessary. Further, I understand that I am responsible for payment of expenses incurred relating to my child's medical treatment. I agree to keep all medical information previously provided about my student up to date.

I acknowledge and understand the risks involved in these events and grant permission for my child to attend and assume those risks. I further agree to release St. Johns County School Board, its officers, agents and employees, exercising reasonable care within their scope of employment, from liability growing out of personal injuries and property damage resulting or occurred during the aforementioned activity and in transit to and/or from the activity. I agree to hold harmless the band director, PVHS Band Boosters, Inc., and any chaperones delegated.

Signature(s):Parent 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_