Central Catholic High School
Requestion for Self-Administration of Medication (OR)
Administration of Medication during School Hours

Central Catholic High School requests that medication be given at home during non-school hours. However, we recognize that some medications will have to be taken during the school day. **ALL MEDICATION TO BE TAKEN AT SCHOOL MUST BE IN THE ORIGINAL CONTAINER. PRESCRIPTION MEDICATION MUST BE IN THE ORGINAL PHARMACY LABELED CONTAINER WITH THE DOSING STRENGTH AND SCHEDULE.**

**** To Be Completed by the Parent****

Student's Name **Birth Date** **Grade**

Physician's Name **Phone Number**

I understand fully the directions that have been given to the school by the physician and agree to permit the school to administer the medication as directed or to monitor the self-administration of the medication by my son. In consideration of Central Catholic's agreement to use good faith efforts to follow the physician's instructions, Central Catholic is hereby relieved from liability for any failure to properly administer or to monitor the self-administration of the medication.

I hereby authorize Central Catholic to contact the physician (named above) regarding this medication and to release information regarding my son (named above) to said physician. I hereby authorize my physician to release information about my son and this medication to Central Catholic for the purposes of supporting the health of my son.

I understand that in order to protect the limited confidentiality of medical information, my agreement to release information is necessary and that this permission is limited for the purpose and to the person or entity listed above and will be effective for the present school year. I understand that the disclosed information will no longer be protected by the Health Insurance Portability and Accountability Act and the releasing facility will not be responsible for re-disclosure of the information. I also understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

Parent/Guardian-Signature Date

**** To Be Completed by Physician****

Diagnosis: _____ Length of Treatment: _____

Medication: _____

Dose, Route, and Schedule: _____

P.R.N. (indications and timing): _____

List of side effects: _____

Physician's Signature: _____ **Date:** _____

H511/336 (Rev. 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 ____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip Code

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day and Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other_____					

☐ **MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health

☐ **RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. _____ Date

Results of Diagnostic Studies: _____ Date

Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ NO ☐ YES _____ Date

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might effect his/her education? If so, specify.

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth & Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number