MEDICAL CERTIFICATE

Due: <u>First Monday in August of each school year</u> (please notify the nurse otherwise)
required annually

This section to be completed by Parent/Guardian

Student Name _____ Date of Birth _____ Grade _____
Last First Middle Month/Day/Year

Address _____ Birth Gender ☐ Male ☐ Female

Parent/Guardian _____ Contact Number (_____)_____

Parent/Guardian _____ Contact Number (_____)_____

1. Immunization – A copy of Immunization Records is **REQUIRED** by the <u>first Monday in August</u> each school year for **NEW STUDENTS and incoming 7th graders**. Record must indicate the month, day, and year of Series and Boosters and medical facility, as required by Texas Department of Health. All immunizations must be current or attendance will be denied.

This is to verify my student had varicella disease (chickenpox) on or about _____ and did not need the varicella vaccine.
Month/Day/Year

<u>Please do not leave any BLANKS</u> (i.e -- or N/A)

2. Health History – Today's Date _____

Food Allergies _____ Drug Allergies _____

Environmental Allergies _____ Heart Conditions _____

Orthopedic Conditions _____ Seizure Disorder _____

Emotional/Psychological/Behavioral Concerns _____

Diabetes ☐ Yes ☐ No Asthma ☐ Yes ☐ No Attention Deficit ☐ Yes ☐ No Bed Wetting ☐ Yes ☐ No

Other previous injuries, illnesses, surgeries _____

List all routine medications _____

_____

3. Administering Medication –

<u>During the School Day</u> – This student may be administered the following medications (or generic equivalent) during the school day: Ibuprofen ☐ Yes ☐ No Acetaminophen ☐ Yes ☐ No Antibiotic Cream ☐ Yes ☐ No

Diphenhydramine Cream ☐ Yes ☐ No Menthol cough/throat drops ☐ Yes ☐ No

Parent Name _____ **Parent Signature** _____

<u>Off Campus Extended &/or Overnight Travel</u> – I give my consent for my child to be administered (per packaging directions) the following non-prescription medications(s) or its generic equivalent by the school staff or designee(s) and **I understand I must provide these over the counter medications**:

☐ Yes ☐ No -Acetaminophen 500mg tabs, 1 or 2 tabs PO Q4h PRN headache or fever

☐ Yes ☐ No -Ibuprofen 200 mg tabs, PO Q4h PRN strain, sprain, muscle aches or pains, menstrual cramps, or dental pain

☐ Yes ☐ No -Antiseptic wipes followed by triple antibiotic ointment and a Band-Aid daily until healed PRN minor cuts and abrasions

☐ Yes ☐ No -Diphenhydramine 25 mg cap, 1 PO Q4-6h PRN allergic reaction (generic Benadryl)

☐ Yes ☐ No -Dextromethorphan cough syrup, 2 teaspoons Q4h PRN cough

☐ Yes ☐ No -Calamine lotion applied to affected areas PRN heat rash or insect bites

☐ Yes ☐ No -Sunscreen SPF 25-30 PRN applied to exposed skin for prolonged exposure to sun

☐ Yes ☐ No - Menthol Cough Drops PRN sore throat/cough

☐ Yes ☐ No -Aloe Vera Gel PRN sunburn or other minor skin irritations

☐ Yes ☐ No –Antacid tablets (Calcium Carbonate) USP 1000 mg.

☐ Yes ☐ No -Stool Softener – Docusate Sodium 100 mg.

☐ Yes ☐ No -Loratadine (Claritin) 10 mg (once daily)

☐ Yes ☐ No -Swimmer's Ear – Drops

Other prescription medication(s) required by the student during school related or extended travel must be supplied by the parents and turned it in the original container, properly labeled, with the name of the student and identification of the medication, the dosage, and the time to be administered by the school staff or designee.

Parent Name _____ **Parent Signature** _____

This section to be completed by PHYSICIAN (must be within the current year)

Physical Examine Date _____

Height _____ Weight _____ Blood Pressure _____ Vision: Right _____ Left _____

	Negative	Positive		Negative	Positive
Skin	_____	_____	Abdomen	_____	_____
Head	_____	_____	Genitalia	_____	_____
Eyes, Ears, Nose	_____	_____	Extremities	_____	_____
Mouth, Throat	_____	_____	Joint Function	_____	_____
Neck	_____	_____	Spine-Scoliosis	_____	_____
Lungs, Chest	_____	_____	Kyphosis	_____	_____
Heart	_____	_____	Lordosis	_____	_____
Hearing	_____	_____	Vision	_____	_____

Date of first menstrual period _____ Date of last menstrual period _____

Explain any abnormal findings _____

I certify that on this date I have examined the above student as indicated by items marked and I recommend him/her as physically able to participate in these supervised activities: Trips ☐ Yes ☐ No Campouts ☐ Yes ☐ No

All Sports/PE ☐ Yes ☐ No Swimming ☐ Yes ☐ No Dance ☐ Yes ☐ No

Exceptions _____

_____ _____ (_____)_____

Printed Name of Physician Signature of Examining Physician Phone Number