John de la Howe School
PRE-PLACEMENT PHYSICAL EXAMINATION

This form is required prior to admissions into either of the John de la Howe School programs. Please have this form completed by your family physician and fax it to (864) 391-2150**. Completion of the physical is not a contract between the applicant, medical facility, or families for placement**. **All**

Student's Full Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Temp:** _____ **Pulse:** _____**(RRR) Respiration:** _____

Hearing (Whisper): **(R):** _____ **(L):** _____ Is an audiometric exam recommended? **Y or N**

Uncorrected Vision: (Snellen) (R): 20/_____ (L): 20/_____ Are corrective lenses worn? **Y or N** Date of last prescription _____

Corrected Vision: (Snellen) (R): 20/_____ (L): 20/_____ Is a complete eye examination recommended? **Y or N**

Dentition (list and describe any problems): _____ Is a dental examination recommended? **Y or N**

Allergies (medication or food): Y or N (if yes, please list them and their reactions): _____

Last Tetanus shot: _____ Has the student had Chicken Pox? _____ If no, has he/she been immunized for this disease? _____

Required Lab Work: (Tests must have been performed within the last 90 days)

URINALYSIS: Date: _____ **Specific gravity:** _____ **Albumin:** _____ **Sugar** _____ **Mic:** _____ **Bacteria:** _____

TUBERCULIN SKIN TEST: Date:_____ **Results:**_____ **Date read:**_____

Key: N=Normal X= Abnormal

_____ **Head**	_____ **Nose**	_____ **Ears**	_____ **Lungs**	_____ **Heart**	_____ **Arches**
_____ **Mouth**	_____ **Throat**	_____ **Abdomen**	_____ **Upper Extremities**	_____ **Spine**	_____**Toenails**
_____ **Eyes**	_____ **Neck**	_____ **Liver**	_____ **Lower Extremities**	_____ **Feet**	

DESCRIBE ANY ABNORMALITIES AND INDICATE RECOMMENDATIONS/RESTRICTIONS (i.e.; No Strenuous Activity):

Last menses (female): _____ **Regular? (Y?N)** _____ **Last examination for hernia (Male):** _____

DIAGNOSIS(ES): **MEDICATIONS (INCLUDING PRNS):**

NEUROLOGICAL: _____ _____

MEDICAL: _____ _____

PSYCHOLOGICAL/EMOTIONAL: _____ _____

I certify that I have personally examined this patient and find no abnormalities, except as indicated above, that would prevent he/she from participating in physical training activities.

DATE: _____ **PRINT AND SIGN:** _____**, M.D.**

ADDRESS: _____ **PHONE:** _____
(A Licensed Physician must complete this form)

John de la Howe School Student Medical History

NAME: _____ Date of Birth: _____ Today's Date: _____

Height: _____ Weight: _____ Social Security Number: _____

Please check any of the following that the student or his/her immediate family may have experienced.
Key: (St=Student, F=Father, M=Mother, S=Sister, and B=Brother)

_____ Anemia
_____ Bronchitis
_____ Cancer
_____ Eyes/Vision
_____ Dental Problems
_____ Ears/Nose/Throat
_____ Diabetes
_____ Epilepsy/Seizures
_____ Hearing Loss
_____ Dizziness or fainting
_____ Headaches (Chronic)
_____ Headaches(Migraine)
_____ Sinusitis
_____ Heart problems
_____ Intestinal problems
_____ Hepatitis
_____ Kidney problems
_____ stomach ulcers
_____ Thyroid problems
_____ Mononucleosis
_____ Neurological
_____ Skin diseases

_____ Sickle Cell
_____ Head Injury
_____ Swollen/Painful Joints
_____ Chronic/frequent colds
_____ Recent weight gain or loss
_____ Pain/Pressure in Chest
_____ Palpitations/pounding heart
_____ High Blood Pressure
_____ Frequent indigestion
_____ Stomach problems
_____ Liver problems/jaundice
_____ Broken bones
_____ rupture/hernia
_____ Frequent/painful urination
_____ Sexually Transmitted Diseases
_____ Arthritis
_____ Bone/joint deformity
_____ Recurrent back pain
_____ Shortness of breath
_____ Chronic cough
_____ Mental illness
_____ Depression/excessive worry

_____ Surgeries
_____ Adverse reactions to drugs
_____ Hemoglobinopathies (i.e.; Sickle Cell and Tay-sachs)

Do you ……
Wear prescription glasses/contacts? Y or N
Wear a hearing aid? Y or N
Smoke? Y or N
Use other tobacco products? Y or N
Use street drugs? (If so please list below Y or N

Have you ever ….
Had bleeding problems? Y or N
Attempted suicide? Y or N
Had any illnesses or injuries other than the ones listed to the left? Y or N
Had any tattoos, piercing, carvings or bands? Y or N

For females only
Are you pregnant? Y or N
Ever been treated for a female disorder? Y or N
Do you use contraceptives Y or N

Are you sexually active? Y or N

For each item checked above, please explain your answer in the space provided below (may use back of sheet if necessary) .

_____
_____
_____

Please list your current medications: _____
_____

Have you even been on medication for **ADD or ADHD? Y or N** Was there any improvement? **Y or N**
What was(were) the name(s), dosage(s) and date(s) of the medication(s)? _____
_____
_____

Why did you stop taking the medication(s)? _____

Have you ever been on medication(s)? **Y or N** Was there any improvement? **Y or N**
What was(were) the name(s), dosage(s) and date(s) of the medication(s)? _____
_____
_____

Why did you stop taking the medication(s)? _____

What is the name of your Health Insurance Company? _____ Effective Date: _____

Whose name is the insurance listed under? _____ Date of Birth: _____

What is the Identification Number or Group Number of the Insurance Policy? _____

_____ Student's Signature

_____ Parent/Guardian's Signature

John de la Howe School
MEDICAL CONSENT

I, _____ hereby voluntarily consent to the rendering of such care, including
(Printed name of parent/guardian)
immunizations, diagnostic procedures, surgical and medical treatment and blood transfusions, by medical doctors, hospitals or their authorized designees, as may in their professional judgment be necessary to provide for the medical, surgical or emergency care of my dependent child, _____
(Printed name of dependent child)

I further give my consent to John de la Howe School to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of my dependent child. In the event that my dependent child is injured or ill while under the care of John de la Howe School, I hereby give permission to John de la Howe School to provide first aid for said child and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

I further give my consent to John de la Howe School to contact my dependent child's routine medical/dental provider(s) as necessary to discuss my dependent child's medical history, medications, and routine and/or ongoing medical/dental needs.

In making medical decisions on my behalf for the benefit of my dependent child, I direct that John de la Howe School attempt to contact me. However, if medical care becomes essential, I give permission to John de la Howe School to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by John de la Howe School on my behalf for the benefit of my dependent child, I authorize John de la Howe School to request, obtain, review and inspect any and all information bearing upon my dependent child's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent child and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent child during this period.

This authorization of consent becomes effective on the _____ day of _____, 20____ and will remain in effect until the child is discharged from John de la Howe School.

Dated this _____ day of _____, 20____.

Parent/Guardian Signature Section

_____
(Printed name of Parent/Guardian)

_____
(Signature of Parent/Guardian)

John de la Howe School Signature Section

_____
(Printed name of John de la Howe School Representative)

_____
(Signature of John de la Howe School Representative)

John de la Howe School
Prescription Medication Authorization Form

Dear Parent or Guardian:

Nonprescription Medications:

Parent/Guardian written authorization is required.

Prescription Medications:

Parent/Guardian written authorization and Physician written authorization is required.

No medication will be administered by John de la Howe School personnel or its agents until the consent forms are completed and on file with the school nurse.

Medication authorization and administration forms will be kept and stored confidentially.

All prescription medication must be in the original container labeled from the pharmacy with the student's name, dosage, time, and quantity to be given.

All medication will be kept in a securely locked area only accessible to those who have the authority to administer medications to the students.

Parents are responsible for bringing/sending medication to the school and picking up any unused medication after it has been discontinued.

Students are not allowed to have medication on their person.

Personnel that administer medication to students will be provided orientation and training.

In accordance with the standards of nursing practice, if the school nurse determines a medication dosage has the potential to be harmful or dangerous, based on her/his experience, assessment and professional judgment, he/she may refuse to administer or allow administration of the medication. In these cases, the school nurse will notify the parent/guardian and the licensed prescriber of the reason for the refusal.

Heather Sizemore, RN
John de la Howe School

John de la Howe School
Medication Authorization Form
(Note: Each medication requires a separate form)

Parent or Guardian to complete this section:

Student's Name: _____ DOB: _____

School: **John de la Howe School** Grade: _____

Medication: _____ Dose: _____

Benefits of medication: _____

Route/Mode of Administration: _____ Frequency: _____

Duration: _____ (Not to exceed current school year)

Times to be given: _____ Start Date: _____ Stop Date: _____

Potential Adverse Reactions: _____

_____

If medication is ordered PRN (as needed), state conditions under which school personnel should administer medication (i.e. headache, fever, pain, cough, etc.):

_____

I hereby give permission for personnel designated by the principal or school nurse to give this medication to my child according to the directions stated.

I also authorize designated personnel to contact me if there is a question regarding medication administration.

I agree to provide documentation from a doctor to the school when the drug is discontinued and/or the dosage or time changed.

I understand if the medication is discontinued and then resumed, a new Medication Authorization Form is required.

I understand that any unused medication will be properly disposed of if not claimed after discontinuation of the medication.

Discontinued medication will be sent home only with the student's parent or guardian.

I agree to hold John de la Howe School, its employees and agents harmless in any and all claims arising from the administration of this medication.

X _____ Date: _____

(Parent or Guardian Signature)

Home Phone: _____ Work Phone: _____

John de la Howe School
Prescription Medication
Physician Authorization

(Please complete a separate authorization for each prescribed medication ordered)

I acknowledge that I will assist and advise designated personnel in the administration of the below prescribed medication.

I agree to provide the school nurse with documentation of the student's follow-up visits and changes of medications/dosages or frequencies.

I will provide copies of prescriptions written to the school nurse for placement in the student's medical record (which will be maintained in the Infirmary), since John de la Howe School is a residential placement.

Student's Name: _____ Date of Birth: _____

Diagnosis: _____

Medication: _____ Dose: _____

Benefits of medication: _____

Route/Mode of Administration: _____ Frequency: _____

Duration: _____ (Not to exceed current school yr.)

Times to be given: _____ Start Date: _____ Stop Date: _____

Special Instructions for Administration: _____

Potential Adverse Reactions: _____

_____

If adverse reactions are noted please notify the student's parent/guardian as soon as possible.

Request that school nurse see the student for any of the following reasons: _____

_____

_____

_____

_____ _____
Physician's Signature Physician's Office Phone Number

_____ _____
Print Physician's Name Date

_____
Physician's Office Address

Over-The-Counter Medications Used

Please check which medications below are approved to use or check here if all below are approved:_____

___A&D Ointment (skin protectant)
___After Bite (bug bites)
___Aloe lotion/gel (burns)
___Antifungal Spray (athlete's foot, jock itch)
___Benadryl (unrelieved itching, hives)
___Ben-Gay (muscle pain)
___Calamine lotion (bug bites/rashes)
___Chigarid (chigger bites)
___Claritin (allergies, sinus problems)
___Compound W (wart remover)
___Cough Drops (cough/sore throat)
___Dimetapp Cold & Cough (cold, sinus problems)
___Ear plugs (protection)
___Emetrol (nausea)
___Epsom Salt (sore joints, ingrown toetails)
___Hydrocortisone Cream (rashes)
___Hydrogen Peroxide (clean wounds)
___Ibuprofen (headaches, cramps, fever, pain)
___Melatonin (sleep aide)
___Mentholatum (chapped lips)
___Milk of Magnesia (laxative)
___Orajel (toothache, sore gum, mouth sore)
___Pepto-Bismol (nausea, diarrhea, upset stomach)
___Senekot (constipation)
___Triple Antibiotic Ointment (cuts, scrapes)
___Tums (heartburn, indigestion)
___Robitussin (cough/cold)
___Tylenol (pain, fever)
___Visine-A (eye allergy)

Parent/Guardian's Initials: _____ Date: _____

Student's Name: _____ Cottage: _____