EMERGENCY CONTACT INFORMATION

Student Information (Please print)

Last | First | MI | SEX | DOB

Insurance Name | Policy Member | Group #

Parent/Legal Guardian (Please print)

Contact EMAIL account (s): ______________________ ________________________

Last | First | MI

Address | City | State | Zip

Daytime Phone Number | Evening Phone Number or Cell

Emergency Contact: Please list someone who can make decisions on your behalf for your son/daughter in an emergency situation.

Name | Relationship

Phone Number | Alternate Phone Number

Name | Relationship

Phone Number | Alternate Phone Number

Parent/Guardian Signature | Date | (OVER)

Medical Information /Medication /Food Allergies /Dietary Restrictions

____

Primary Physician Address Phone Number

____

Dentist Address Phone Number

Medication Allergies:

1. ____
2. ____
3. ____
4. ____

Food Allergies:

1. ____
2. ____
3. ____
4. ____

Dietary Restrictions:

1. ____
2. ____
3. ____
4. ____

Medical Diagnoses:

1. ____
2. ____
3. ____
4. ____

Medication List:

1. ____________________ 7.____________________
2. ____________________ 8. ____________________
3. ____________________ 9. ____________________
4. ____________________ 10. ____________________
5. ____________________ 11. ____________________
6. ____________________ 12. ____________________

The SEED School of Maryland

Información de Contacto de Emergencia

Información de estudiante (en letra de imprenta)

Apellido nombre | Primer nombre | Media incia | Fecha de nacimiento

Nombre de Seguro | política de los miembros | grupo #

Principal/Legal tutor (en letra de imprenta)

EMAIL contacto (s): ________________________ ______________________

Padre información (en letra de imprenta)

Apellido nombre | Primer nombre | Media incia

Dirección | Ciudad | Estado | Código postal

Número de teléfono de noche | Número de teléfono durante el día

Contacto de emergencia: Lista, por favor, alguien que puede tomar decisiones en su nombre para tu hijo / hija en una situación de emergencia.

Nombre | Relación

Número de teléfono | alternativo número de teléfono

Nombre | Relación

Número de teléfono | alternativo número de teléfono

Nombre | Relación

Número de teléfono | alternativo número de teléfono

Información médica/medicamentos/alimentación alergias/dietéticos restricciones

____

Nombre del médico de atención primaria   dirección   Número de teléfono

____

Nombre del dentista   dirección   Número de teléfono

Alergias de medicamentos:

1. ____
2. ____
3. ____
4. ____

Alergias a los alimentos:
1. ____
2. ____
3. ____
4. ____

Restricciones dietéticas:

1. ____
2. ____
3. ____
4. ____

Diagnósticos médicos:

1. ____
2. ____
3. ____
4. ____

Lista de medicamentos:

1. ______________________ 7.____________________
2. ______________________ 8. ____________________
3. ______________________ 9. ____________________
4. ______________________ 10. __________________
5. ______________________ 11. __________________
6. ______________________ 12. __________________

The SEED School of Maryland

The SEED School of Maryland Sick Policy

1. If a child is sick or has been injured, or is otherwise not able to remain in class, he/she will be sent to the school nurse for evaluation and to determine if it is safe for the child to remain in school.
2. The nurse on duty will provide first aid treatment for any injuries.
3. After evaluation, the nurse will notify the parent/guardian if the student is found to have:
    a. A fever of 100.4 degrees (F) or higher
    b. Vomiting or diarrhea
    c. Suspected concussion
    d. Injury with swelling and/or decreased functioning (e.g., difficulty walking)
    e. Injury requiring stitches
    f. Difficulties with breathing, vision, or hearing
    g. Symptoms of an illness considered contagious.
    h. Student request when indicated and/or per parent request
4. The school nurse will determine if the child is safe to remain in school or whether he/she needs further evaluation and treatment. This usually requires a child to be picked up from school by a parent or guardian.
5. A student sent home due to an injury will need to be evaluated by a medical provider and is **required to bring a note from the doctor detailing the nature of the injury, authorization to return to school, and any activity restrictions that may apply.**
6. If a child needs medication, the treating physician must complete a Maryland State Medication Authorization Form. It is important to note that the nurse on duty can only dispense medications prescribed by the medical professional if the **appropriate documentation** is provided.
7. If a child does not have the Medication Authorization Form, the child will not be medicated and the parent will be responsible for coming to campus to medicate his/her child if necessary.
8. **If a child has a fever of 100.4 degrees (F) or above, is vomiting, has diarrhea, or any symptoms that could be considered contagious without treatment or is otherwise not well enough to participate in school activities, he/she will be sent to the nurse on duty for evaluation. The parent will be contacted immediately to provide verbal consent for any temporary treatments and will be required to make arrangements to pick up the child from school. The child will be triaged in the nurse's station and kept comfortable until the parent arrives.**
9. A student sent home with a fever, vomiting, diarrhea or any other serious symptoms, will need to be evaluated by a physician and **may return to school when symptom free for 48 hours and with a note from the doctor stating that the student was evaluated and may return to school.** Students who return to school sick or are noted to be sick at check in will be sent back home.

Student Name: ____DOB: _____________

Parent/Guardian Signature: _____________________________________ Date: ______________

SEED School of Maryland
Consent for Release of Information

Our school understands that your office needs consent to release health information, except as provided in our Notice of Privacy Practices.

Signing this form authorizes release of student's medical/clinical information including dates, history of illness, diagnosis, and treatment. Please note that we must have a physician's order to administer any medication. His/her completing the Maryland State Medication Authorization Form will provide such an order. Any records released will be stored in our confidential files.

Student Name: ________________________________ DOB: ____________________________

Address: _____________________________________ Telephone #: ____________________

Information to be released:

- ☐ Copy of health record
- ☐ History and Physical
- ☐ Other: _______________
- ☐ Abstract
- ☐ Discharge Summary
- ☐ Operative Report

Program: ____

Address: ____

Telephone: ____

The information will be released for the following purpose(s):

______ Request of Student ______ Treatment ______Insurance ______Other

The facility, its employees, officers and medical staff are released from legal responsibility or liability from the release of the information in accordance with this consent.

Signature: ___________________________________ ___________________

Parent/Guardian Date

Printed Name: ______________________________________ Relation: _________________

Consent for Release of Information

You may revoke this authorization at any time. See the Notice of Privacy Practices for more information about revoking authorization.

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from us ***EXCEPT*** in the following circumstances:

- If the only purpose for providing you with a service is to obtain information to disclose to someone else, then you must authorize that disclosure in order to receive the service. (Example: physical examinations required to obtain certain types of licenses).
- If the services are related to research, you may be required to separately authorize the use or disclosure of your health information for the research. This applies only to your health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to others.

The SEED School of Maryland

Consentimiento para la Divulgación de Información

Nuestra escuela entiende que su oficina necesita consentimiento para divulgar información sobre la salud, salvo lo dispuesto en nuestro Aviso de Prácticas de Privacidad.

La firma de este formulario autoriza la divulgación de la información del estudiante de medicina/clínica, incluyendo las fechas, los antecedentes de enfermedades, diagnóstico, y tratamiento. Tenga en cuenta que tenemos que tener una orden médica para administrar cualquier medicamento. Completar el Formulario de Autorización Médica del Estado de Maryland proveerá dicha orden. Cualquier discos editados serán almacenados en nuestros archivos confidenciales.

Nombre del estudiante: ____________________________ Fecha de Nacimiento: ____________

Dirección: ___ ____Teléfono #:_________________

Información que se entregará:

☐ Copia del registro de salud
☐ Historia y Física Resumen
☐ Otro: ________________
☐ Resumen
☐ Discharge Reportar
☐ Operativo Reportar

Programa: ____

Dirección: ____

Teléfono:____

La información se dará a conocer con el objetivo siguiente (s):

Solicitud del Estudiante____ Tratamiento Seguros______ Otro_______

La instalación, sus empleados, funcionarios y el personal médico se liberan de la responsabilidad legal o responsabilidad por la liberación de la información de acuerdo con este consentimiento.

Firma: ____________________________________ ____________________________
Padre / Tutor Fecha

Nombre Impreso: __________________________ Relación:______________________

Consentimiento para la Divulgación de Información

Usted puede revocar esta autorización en cualquier momento. Véase el Aviso de prácticas de privacidad para obtener más información acerca de la revocación de la autorización.

Usted puede negarse a firmar esta autorización. Usted no tiene que firmar esta autorización para recibir servicios de nosotros, excepto en las siguientes circunstancias:

- Si el único propósito para el que le proporciona un servicio es obtener información a revelar a otra persona, entonces usted debe autorizar que la divulgación con el fin de recibir el servicio. (Ejemplo: los exámenes físicos requeridos para obtener ciertos tipos de licencias).

- Si los servicios están relacionados con la investigación, es posible que tenga que autorizar por separado el uso o divulgación de su información de salud para la investigación. Esto se aplica sólo a la información sobre su salud relacionada con los servicios de investigación. El uso y divulgación de su información se limitarán a lo estrictamente necesario para la investigación. Si no autoriza el uso y divulgación de su información para la investigación, es posible que no sea elegible para recibir los servicios.

Una persona u organización que recibe su información de la presente autorización podrán tener el derecho legal de revelar dicha información a terceros.

The SEED School of Maryland

The SEED School of Maryland Hospitalization Policy

1. In the event that a student requires emergent care, he/she will be transported to the St. Agnes Hospital Pediatric Emergency Room or the University of Maryland Medical Center via ambulance, accompanied by an adult from the Seed School of Maryland.
2. The Nurse or Student Life Manager on duty will immediately notify the parent/guardian of the situation and request that he/she come to the hospital to attend the child.
3. An adult from the Seed School of Maryland will remain at the hospital with the student until the parent/guardian arrives.
4. If the student requires admission to the hospital, he/she will be admitted under the care of the hospital physician/nurse practitioner with the consent of the parent/guardian.
5. Parents/guardians/grandparents are permitted to stay with the student 24 hours a day.
6. Once the student is seen in the ER and released, he/she will be discharged into the care of the parent/guardian.
7. Parents/guardians must provide the SEED School of Maryland with consent to obtain any information about hospitalization from the hospital.
8. Please provide the SEED School Nurse a copy of the discharge summary and/or recommendations for care. Prescriptions can be administered if accompanied by a physician's order.

Emergency Preparedness

1. In the event that there is a major disaster or mass casualties involving the SEED School of Maryland, students may be triaged at the St. Agnes Hospital Emergency Room or the University of Maryland Medical Center.
2. Severely injured students will be transported via ambulance to the closest shock-trauma centers with Intensive Care Units -- University of Maryland Medical Center, Johns Hopkins Hospital or Sinai Hospital.
3. All parents/guardians will be contacted **immediately** in the event of a major disaster or mass casualties involving the SEED School of Maryland.

Student Name: ____________________ DOB: ______________

Parent/Guardian Signature: _____________________________ Date: _______________

The SEED School of Maryland

POLÍTICA DE HOSPITALIZACIÓN

1. En el caso de que su hijo necesita atención de emergencia, se le será enviado a la sala Santa Inés de emergencia en ambulancia Hospital Pediátrico acompañados por un adulto de la Escuela de semillas de Maryland.
2. La enfermera de turno o de Vida Estudiantil gerente de turno notificará inmediatamente a los padres / tutores de la situación y le dará instrucciones para ir a la sala Santa Inés de emergencia del Hospital Pediátrico para que pueda estar con su hijo.
3. El alumno estará acompañado por un adulto de la Escuela de semillas de Maryland en todo momento hasta que el padre llega al hospital.
4. Una vez que el estudiante se ve en la sala de emergencia, se le dará de alta para el cuidado de los padres o tutores.
5. Si el estudiante requiere ingreso en el hospital, él o ella serán admitidos bajo el cuidado de la asistencia hospitalaria pediátrica en el servicio.
6. Una vez admitido en el hospital, el estudiante será trasladado a una unidad pediátrica.
7. Los padres, tutores o abuelos se les permitirá quedarse con el estudiante de 24 horas al día.

PREPARACIÓN PARA CASOS DE EMERGENCIA

1. En el caso de que haya víctimas de un desastre mayor o masa de semillas participación de la Escuela de Maryland, los estudiantes pueden ser clasificados en la sala de emergencias del Hospital Santa Inés y si es necesario se enviará al centro más cercano de choque-trauma. Hospital St. Agnes no tiene un centro de trauma.
2. los estudiantes gravemente heridos serían transportados en ambulancia a la cercana centros de trauma shock, con unidades de cuidados intensivos de la Universidad de Maryland Hospital, Johns Hopkins Hospital y el Sinaí Hospital.
3. Todos los padres / tutores se puso inmediatamente en contacto en caso de víctimas de un desastre mayor o masa de semillas participación de la Escuela de Maryland.

Nombre del alumno: ____________________ DOB: _____________

Firma del padre o tutor: ____________________________ fecha: ____________________

AUTHORIZATION TO SEEK MEDICAL CARE

Student Name: ____________________________________

Date of Birth: ______________________

Parent/Guardian Name: ____

Parent Address: ____

____

This form gives The Seed School of Maryland authorization to seek medical care for your minor child.

I (parent/guardian) __________________________________ (relationship to student) ___________ authorize The Seed School of Maryland to seek medical care for my child, including but not limited to, Emergency Room visits, emergency hospitalization, emergency mental health treatment, emergency medical treatment, including medical procedures and/or routine medical care.

Health insurance:

____

Insurance Provider Policy Number Group #

Parent/guardian Signature: _________________________________Date:_______________

The SEED School of Maryland

AUTORIZACIÓN a Buscar Atención Médica (para situaciones de emergencia sólo)

Nombre del estudiante: ___________________________________

Fecha de nacimiento: ______________________

Nombre del padre o tutor: ____

Dirección de los padres: ____

____

Este formulario da autorización de la escuela The SEED School of Maryland a buscar atención médica de emergencia para su hijo menor.

Yo (padre o tutor) __________________________________ (relación con el estudiante) ___________ autorizar The SEED School of Maryland a buscar atención médica de emergencia para mi hijo, incluyendo pero sin limitarse a, las visitas sala de urgencias, hospitalización de emergencia, el tratamiento médico de emergencia o procedimientos médicos en caso de que se trate de una situación de emergencia.

Seguro de salud:

____

Número de norma de proveedor de seguros grupo #

Firma del padre o tutor: ________________________________Fecha:_________________

The SEED School of Maryland

TRANSPORTATION AUTHORIZATION FORM

Student Name: ____

Date of Birth: ____

Parent/Guardian Name: ____

Parent/Guardian Address: ____

Parent/ Guardian Phone Number: ____

The SEED School of Maryland staff members occasionally need to transport students.

This permission slip gives The SEED School of Maryland personnel authorization to transport your minor child in their personal vehicles, per a professional transportation company or via ambulance as needed.

I (Parent/Guardian) _________________________ (relationship to student) _____________ authorize The SEED School of Maryland to transport my child.

Parent/Guardian Signature: __________________________ Date: __________________________

Relationship to Student:_______________________________

■ Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ______		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ______

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HE0503 9-2681/0410

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____

Name ____ Date of birth ______________

Sex ________ Age ________ Grade ________ School ______________________ Sport(s) ______________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________________ Signature of parent/guardian ______________________ Date ____________

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■ Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name ____ Date of birth __________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ____
  - Reason ____

Recommendations ____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________________ Date ______________

Address ____ Phone ______________

Signature of physician ____, MD or DO

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■ Preparticipation Physical Evaluation
CLEARANCE FORM

Name ______________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________
- Reason ______________________

Recommendations ______________________

____

____

____

____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________ Date __________

Address ______________________ Phone __________

Signature of physician ______________________, MD or DO

EMERGENCY INFORMATION

Allergies ______________________

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Other information ______________________

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AUTHORIZATION FOR VISION TREATMENT

Student Name: ____

Date of Birth: ____

Parent/Guardian Name: ____

Parent/Guardian Address: _______________________________________

Parent/ Guardian Phone Number: __________________________________

The Baltimore City Health Department evaluated your child during a scheduled Vision & Hearing Screening; your child failed the Vision test. Your child needs follow up vision evaluation and treatment.

This permission slip gives The SEED School of Maryland authorization to have your minor child examined by the Ophthalmologist and evaluated at LensCrafters to provide vision treatment.

I (Parent/Guardian) ___________________________ (relationship to student) ______________ authorize The SEED School of Maryland to have my child examined by Dr. Barry Blum and evaluated at LensCrafters in order to participate in the Eye Glass Program which provides students eye glasses free of charge.

Dr. Barry Blum, MD
Wilmer Green Spring Station,
Pavilion 2, 4th floor
(410) 583 – 2800

LensCrafters
2400 Boston St, Suite 106
Baltimore, Maryland 21224
(410) 675 – 0434

Parent/Guardian Signature: ______________________________ Date: ________________

Smile Maryland
Oral Health Impact Project

THE DENTIST IS COMING TO YOUR SCHOOL!

Our school has joined with Smile Maryland Oral Health Impact Project to offer in-school dental care at NO COST* to you.

Taking care of your child's teeth is important to keep them healthy.

EASY & CONVENIENT - A state licensed dentist will regularly check your child's mouth & teeth, as well as provide a cleaning, x-rays as necessary, fluoride treatment and apply sealants, as needed. Additional care, such as fillings, may also be provided. A dental report card will be sent home with your child. Includes initial dental care & follow-up visits. **SIGN AND RETURN TO YOUR SCHOOL TODAY!**

PLEASE COMPLETE

Child's Legal Name		Birth Date	☐ Male ☐ Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	

MEDICAL INFORMATION - Check each condition that applies to your child. Approx. date of last dental visit ____________

☐ Dental problems____________ ☐ Heart problems/valve replacements/shunts ☐ Asthma/breathing problems

☐ Epilepsy/seizures ☐ Allergies____________ ☐ Current medications____________ ☐ Antibiotic premedication required

☐ Other health problems (i.e., diabetes, bleeding problems, communicable diseases, etc.)? Explain (attach additional pages as needed) ____________

FOLD

IF CHILD HAS MEDICAID/MARYLAND HEALTHY SMILES

Enter Child's 11-digit Medicaid Recipient ID Number HERE: → ☐☐☐☐☐☐☐☐☐☐☐

***Medicaid & Maryland Healthy Smiles Program cover 100% of treatment**

OR Child's Social Security # (if available) ☐☐☐ - ☐☐ - ☐☐☐☐

IF CHILD HAS PRIVATE INSURANCE

Ins. Company name (other than Medicaid)____________ Ins. Phone____________

Group #____________ Employer name____________ Co. phone____________

Name of Insured Adult____________ BIRTH DATE of Insured Adult ____________

Member ID/Policy #____________ Social Security # of insured adult ____________

IF CHILD HAS NO DENTAL INSURANCE

☐ I request donated care to cover the cost of a dental cleaning, screening and fluoride for my child. (We will send you a donated care application. Available only once per school year for preventive care only.)

READ & SIGN BELOW

I request that the dentist perform a dental check-up on my child at school which includes exam, cleaning, fluoride, sealants and x-rays as needed, as well as other dental work as needed, including fillings, extractions of infected baby teeth, numbing the mouth and teeth and other procedures as described more fully on the back of this page. This permission includes future dental visits. I have read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS PAGE and understand and agree to its terms.

SIGN & DATE HERE ____________ ____________ DATE

OFFICE USE ONLY		
1st	6 mo	
		exam, prophy, fluoride
		exam, prophy
		(4)bwx or (2)bwx
		PA films for diagnosis
		seal (M)molars (MB)molars & bicuspids
		csf

For your privacy, please fold & secure.

QUESTIONS: Smile Maryland: 1-888-833-8441
OHIP: 1-866-916-6447

Visit us at: mobile dentists.com
ohip.us

MD-OHIP-009-REM 6/15

Solomon K. Pesis, D.D.S. - General Dentist & Dental Director
S.K. Pesis D.D.S., Big Smiles Maryland, PC, 8639 B 16th St. #271, Silver Spring, MD 20910
OHIP Lawrence B Caplin DMD, P.A
6097 Easton Road, Pipersville, PA 18947

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ESPAÑOL AL REVERSO

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

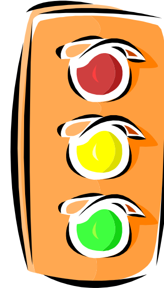
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Maryland Chapter

ASTHMA ACTION PLAN

Check Asthma Severity: ☐Mild Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Patient's Name	DOB	Effective Date ___/___/___ to ___/___/___
Doctor's Name	Parent/ Guardian's Name	
Doctor's Office Phone Number	Parent/ Guardian's Phone Number	
Emergency Contact after Parent	Contact Phone	



Personal Best Peak Flow: ______

Personal Peak Flow Ranges

RED means Danger Zone! Get help from a doctor. -- ________

YELLOW means Caution Zone! Add prescribed yellow medicine. -- ________

GREEN means Go Zone! Use preventive medicine. -- ________

GO (Green) → Use these medications every day.

You have *all* of these:

- Breathing is good.
- No cough or wheeze.
- Sleep through the night.
- Can work and play.

And/ or personal peak flow above 80 % ________

Medicine/ Dosage	How much to take	When to take it
Comments		

For exercise, take:

CAUTION (Yellow) → Continue with green zone medicine and ADD:

You have *any* of these:

- First sign of a cold.
- Exposure to a known trigger.
- Cough.
- Mild wheeze.
- Tight chest.
- Cough at night.

And/ or personal peak flow from 80% ________ To 50% ________

Medicine/ Dosage	How much to take	When to take it
Comments		

If Quick Reliever/ Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor.

DANGER (Red) → Take these medicines and call your doctor.

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes.
- Breathing is hard and fast.
- Nose opens wide.
- Ribs show.
- Lips are blue.
- Fingernails are blue.
- Trouble walking or talking.

And/ or personal peak flow below 50% ________

Medicine/ Dosage	How much to take	When to take it
Comments		

GET HELP FROM A DOCTOR NOW!

If you cannot contact your doctor, go directly to the emergency room.
DO NOT WAIT.

Trigger List:

- ❑ Chalk dust
- ❑ Cigarette smoke
- ❑ Colds/Flu
- ❑ Dust or dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods: ________ ________
- ❑ Other: ________

Adapted from: NYC DOHMH and Pediatric/ Adult Asthma Coalition of New Jersey.

www.fha.state.md.us/mch www.MarylandAsthmaControl.org www.mdaap.org

White Copy- Patient **Pink Copy- School** **Yellow Copy- Doctor**

DHMH Form Number: 4643

For additional forms, please call: 410-799-1940

How to Use this Form

The Asthma Action Plan is to be completed by a primary care provider for each individual (child or adult) that has been diagnosed with asthma. The Asthma Action Plan should be regularly modified to meet the changing needs of the patient and medicine regimes. The provider should be prepared to work with families to gain an understanding of how and when the Asthma Action Plan should be used. *Please complete all sections of the Asthma Action Plan. Please write legibly, and refrain from using abbreviations.*

The Asthma Action Plan is an education and communication tool to be used between the health care provider and the patient, with their family and caregivers, to properly manage asthma and respond to asthma episodes. The patient, and their family or caregivers, should fully understand the Asthma Action Plan, especially related to using the peak flow meter, recognizing warning signs, and administering medicines. Patients, families, and caregivers should be given additional educational materials related to asthma, peak flow monitoring, and environmental control.

Persons with asthma, parents, grandparents, extended family, neighbors, school staff, and childcare providers are among the persons that should use the Asthma Action Plan.

A spacer should be prescribed for all patients using a metered-dose inhaler (MDI).

Children over the age of six years may be given peak flow meters to monitor their asthma and determine the child's zone.
Parents of children under the age of six years should use symptoms to determine the child's zone.

Zone Instructions

The Personal Best peak flow should be determined when the child is symptom free. A diary can be used to determine personal best and is usually part of a peak flow meter package. A peak flow reading should be taken at all asthma visits and personal best should be redetermined regularly. Because peak flow meters vary in recording peak flow, please instruct your patients to bring their personal peak flow meter to every visit.

Green: Green Zone is 100 percent to 80 percent of personal peak flow best, or when no symptoms are present.
List all daily maintenance medicines. Fill in actual numbers, not percentages, for peak flow readings.

Yellow: Yellow zone is 80 percent to 50 percent of personal peak flow best, or when the listed symptoms are present.
Add medicines to be taken in the yellow zone and instruct the patient to continue with green zone (maintenance) medicines. Include **how long** to continue taking yellow (quick reliever) medicines and when to contact the provider.

Red: Red zone is 50 percent or below of personal peak flow best, or when the listed symptoms are present.
List any medicines to be taken while waiting to speak to a provider or preparing to go to the emergency room.

Peak Flow Chart

Green 100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320
Yellow 80%	80	90	95	105	110	120	130	135	145	150	160	170	175	185	190	200	210	215	225	230	240	250	255
Red 50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160

Green 100%	330	340	350	360	370	380	390	400	420	440	460	480	500	520	540	560	580	600	620	640	660	680	700
Yellow 80%	265	270	280	290	295	305	310	325	335	350	370	385	400	415	430	450	465	480	495	510	535	545	560
Red 50%	165	170	175	180	185	190	195	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) __________________ including the summer session.

School: ____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: ________________________ Date of Birth: ____________________ Grade: _________

Condition for which medication is being administered: ____

Medication Name: ___________________________Dose: ______________Route: _____________

Time/frequency of administration: _______________________________ If PRN, frequency: _____________

If PRN, for what symptoms: ____

Relevant side effects: ☐ None expected ☐ Specify: ______________________________________

Medication shall be administered from: ______________________to______________________
Month / Day / Year Month / Day / Year

Prescriber's Name/Title:___________________________
(Type or print)

Telephone: ________________FAX: _______________

Address:___________________________________

____

Prescriber's Signature: ____________________Date:________
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): ____________________ for the above medication on (Date): __________

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: ____ Date: _______________

Home Phone #: _________________ Cell Phone #: ____________________ Work Phone #: _________________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _______________________
Signature Date

School RN approval for self carry/self administration of emergency medication: __________________________
Signature Date

Order reviewed by the school RN: ____
Signature Date

2004