ANC

ACADEMY OF THE NEW CHURCH

DEADLINE
The form must be submitted by June 30, 2017

❑ C
❑ S

Questions? Call: 267-502-4582

YEARLY PHYSICAL FOR NEW STUDENTS

Must be completed and signed by parent or guardian.

This form must be submitted by June 30, 2017 to: Doering Health Clinic, 2800 Buck Rd, Box 710, Bryn Athyn, PA 19009.

Student Name: _____ Male: ___ Female: ___ Date of Birth: _____ Grade: _____

Address: _____ Cell phone _____

Allergies or life-threatening conditions: _____

Emergency Contact:

Father/Guardian: _____ Home phone: _____ Cell phone: _____

Mother/Guardian: _____ Home phone: _____ Cell phone: _____

Parent/Guardian E-mail address: _____

Health Insurance Information:

The Academy of the New Church requires all students to be covered by a comprehensive health insurance plan that can be used in the state of Pennsylvania. *Please note that other state-specific medicaid will not pay for care in Pennsylvania. Parents are responsible to determined viability of their insurance in Pennsylvania and to resolve any coverage issue before the start of school. All international students must purchase U.S. insurance through ANC. ***Please include a copy of your insurance card****

Insurance Carrier: _____ Group: _____ Policy ID: _____

Policy Holder's Name: _____ Date of Birth: _____

Immunization Record:

The Pennsylvania Department of Health requires schools to submit a complete immunizations record for each enrolled student. A student may not register for nor attend classes at the Academy of the New Church until the Student Health Center receives the required completed Certificate of Immunization (or an equivalent document) signed by the student's physician or school nurse from the school previously attended.

	Immunization Record	Dates Administered				
*Required	DPT (Diptheria, Pertussis, Tetanus) or TdaP *4 doses*					
*Required	Tetanus Diphtheria and Acellular Pertussis (Tdap preferred - booster less than 5 years)					
*Required	OPV/IPV (Polio) *3 doses*					
*Required	MMR (Measles, Mumps, Rubella) *2 doses*					
*Required	Hepatitus B *3 doses*					
*Required	Varicella *2 doses or date of chickenpox illness*			*Date of illness:*		
*Required	Meningitis vaccine (MCV) *If first dose is given 11-15 years of age; a second dose is required at age 16 or entry into 12th grade.*					
Recommended	HPV *3 doses*					
Other						

Required by Pennsylvania state law May 2017.

Religious Exemption: *(Includes a strong moral or ethical conviction similar to a religious belief.)*

Parent or guardian of the above named child adheres to a religious belief whose teachings are opposed to such immunizations.

State your reason for requesting a religious exemption: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Permission-to-Treat: Must be signed!

In the event that I cannot be reached, I hereby give my consent for emergency treatment or non-emergency tests or diagnostics deemed necessary for the above named ANC student according to the judgement of the attending physician, nurse, athletic trainer, and/or designee.

Parent/Guardian Signature: _____

REQUIRED

STUDENT INFORMATION SECTION

Must be completed by parent or guardian.

Student Name: _____ **Date of Birth:** _____

Medical Conditions:

Please check yes if your child has ever had, or now has, any of the following conditions *(check all that apply):*

YES
- ❑ **Allergies**
- ❑ **Alcohol/drug abuse**
- ❑ **Anemia**
- ❑ **Anxiety or panic attacks**
- ❑ **Asthma, including exercise induced**
- ❑ **Attention Deficit Disorder**
- ❑ **Bee sting allergies**
- ❑ **Blood clotting disorder**
- ❑ **Cancer**

YES
- ❑ **Chickenpox** DATE: _____
- ❑ **Crohn's disease/ulcerative colitis**
- ❑ **Diabetes**
- ❑ **Eating Disorder**
- ❑ **Epilepsy/seizures**
- ❑ **Fainting/blackouts**
- ❑ **Food allergies**
- ❑ **Headaches, frequent or severe**
- ❑ **Heart murmur, arrhythmia**

YES
- ❑ **Heat-related illness**
- ❑ **Hepatitis**
- ❑ **High blood pressure**
- ❑ **Kidney disease**
- ❑ **Meningitis/encephalitis**
- ❑ **Menstrual problems**
- ❑ **Mononucleosis**
- ❑ **Ovarian cyst**
- ❑ **Pertussis** DATE: _____

YES
- ❑ **Pneumonia**
- ❑ **Positive tuberculin skin test**
- ❑ **Sickle cell trait/disease**
- ❑ **Thyroid condition**
- ❑ **Urinary tract infection**
- ❑ **Other**

If you answered "yes" to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any conditions or medical history not listed:

_____

_____

List dates of any known concussions or head injury: _____

List all other surgical procedures (except treatment of fractures) with dates: _____

List all medical/psychiatric hospitalizations or treatment with dates: _____

Counseling/psychotherapy in the last six months: _____

List any medications taken regularly, including contraceptives: _____

Do you have an EpiPen? List allergy/reaction history: _____

Please check yes if your family (parents, grandparents, siblings) has a history of any of the following conditions:

YES
- ❑ **Blood clotting disorder**
- ❑ **Cancer**
- ❑ **Diabetes**
- ❑ **Epilepsy**
- ❑ **Heart arrhythmea**

YES
- ❑ **Heart disease**
- ❑ **High blood pressure**
- ❑ **Kidney disease**
- ❑ **Mental illness**
- ❑ **Migraine**

YES
- ❑ **Sudden death**
- ❑ **Thyroid disease**
- ❑ **Other**

Student is cleared for all levels of physical and sports activities: ❑ **YES** ❑ **NO**

If no, please explain: _____

Parent/Guardian Signature: _____ Date: _____ REQUIRED

Permission for concussion testing:

I give permission for (name of child)_____to have a post-concussion computerized cognitive assessment administered by the athletic trainer at no charge, if needed. REQUIRED

I understand that ANC has protocols for management of sports injuries, and I agree that my child will abide by such protocols.

Parent/Guardian Signature: _____ Date: _____ REQUIRED

PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICINE:

Below are the medications available to students administered by the school nurse. Please review carefully and check yes or no for your child.

Student Name: _____ **Date of Birth:** _____

Medications:

YES	NO	
❑	❑	1. Acetaminophen: 325mg or 500mg tablets as needed for pain.
		a. May repeat every 4-6 hours, not to exceed 6 tablets in 24 hours.
❑	❑	2. Ibuprofen: 200mg tablets as needed for pain.
		a. May repeat every 4 hours, not to exceed 6 tablets in 24 hours.
❑	❑	3. Sudanyl PE (phenylephrine): (1 or 2) 5mg tablets for sinus congestion
		a. May repeat every 4-6 hours, not to exceed 6 tablets in 24 hours.
❑	❑	4. Loratadine: (1) 10mg tablet daily as needed for cold/allergy symptoms per directions on package.
❑	❑	5. Cough Drops
❑	❑	6. Tums chewable: 2 tablets for indigestion, repeat as directed by manufacturer.
❑	❑	7. Loperamide HCL: 2mg caplets as needed for diarrhea.
		a. Two caplets after first loose stool, then 1 caplet after subsequent loose stools, not to exceed 4 caplets in 24 hours.
❑	❑	8. Miralax 17g dissolving: Once a day according to package directions for constipation.
❑	❑	9. Homeopathic remedies as prescribed by camper's homeopathic practitioner.
❑	❑	10. Benadryl or generic equivalent: 25mg to 50mg capsules or liquid as needed for allergic reaction, itching from poison ivy, or swelling from bee sting.
❑	❑	11. Epi-Pen auto injector: 0.3 mg as needed for acute allergic reaction.
		a. Administered only in acute allergic response evidenced by signs of impending anaphylaxis or self-report of ingestion of life-threatening allergens.

Authorization:

- I have reviewed these Standing Orders. Permission is granted for the Director of Student Health Services or designee to provide these medications for my son/daughter for minor illness or discomfort.
- I have indicated by checking "no" on any medications that I do **not** wish my child to have.
- I hereby release and hold harmless the Academy of the New Church, its employees, directors, agents, and assigns from any liability, claims, demands, actions and/or attorneys' fees from the administration of medication to the above noted student in accordance with this form.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

PHYSICIAN'S SECTION

Must be completed and signed by healthcare professional between May 1, 2017 and August 1, 2017.

Student Name: _____ **Date of Birth:** _____

The physical examination must be completed between May 1, 2017 and August 1, 2017. Please review the health history provided above. Add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student's physical and emotional status, both for the student and as a basis for her/his continuing medical care.

Height _____ **Weight** _____ **Blood pressure** _____ **Pulse** _____ **RR** _____

Vision: Uncorrected R 20 _____ **L 20** _____ **Corrected R20** _____ **L20** _____

Physical Exam	Normal	Abnormal	Explanation of Abnoral Findings
Head/Eyes/ENT			
Neck/Lymph/Thyroid			
Cardiovascular			
Respiratory			
Breast exam			
Abdomen			
Hernia/Testicles			
Musculo-skeletal			
Neurologic			
Skin			

Allergies or life-threatening conditions: _____

Details related to above topics, additional information, comments, or activity restriction: _____

_____

IS THIS STUDENT CLEARED FOR SPORTS? ❑ **YES** ❑ **NO** Details: _____

Treatment: Is this student currently receiving medical treatment that should be continued while at school? ❑ **YES** ❑ **NO**

If yes, name: _____

Medications: List all prescribed medications the student is taking and the prescribed dosages and frequency. _____

_____

_____

Is the student capable to self-administer prescribed medications if needed, including EpiPen and inhalers if needed? ❑ **YES** ❑ **NO**

Tuberculosis test is required for admission.
An intradermal tuberculin test must be given within seven months of the start of school, March-September. Please attach results.

Date: _____ Results: ❑ **Negative** ❑ **Positive** _____ mm. induration Chest X-ray result: _____

Physician Signature: Must be signed! REQUIRED

I have examined this child and certify her/his condition is as described on this page.

Physician Name (please print): _____ **Exam Date:** _____
(must be between May 1, 2017 and August 1, 2017)

Physician Signature: _____

Physician Full Address: _____

Telephone: _____ Fax: _____

ANC

Completed Health Form must be returned at the same time as registration.

Questions? Call: 267-502-4582

CONCUSSION CONSENT FORM

Please fill out this form and return to: **Doering Health Clinic, 2800 Buck Rd, Box 710, Bryn Athyn, PA 19009**

Student Name: _____ Date of Birth: _____ (Month) / _____ (Day) / _____ (Year) Gender: ❑ Male ❑ Female

CONCUSSION MANAGEMENT

DEFINITION

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells.

CONCUSSIONS ARE SERIOUS

Medical providers may describe a concussion as a "mild" brain injury because concussions are usually not life-threatening. Even so, the effects of a concussion can be serious.

If the athlete reports one or more of the signs and symptoms listed below, or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body, they may have a concussion or more serious brain injury.

CONCUSSION SIGNS OBSERVED

- Can't recall events prior to or after a hit or fall.
- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (even briefly).
- Shows mood, behavior, or personality changes.

CONCUSSION SYMPTOMS REPORTED

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down"

A child or teen with a concussion needs to be seen by a medical provider. If you think your child or teen has a concussion, contact his or her health care professional.

REMOVE FROM PLAY

If the concussion happens while playing sports:

1. Remove the athlete from play.
2. The athlete must tell coach, ANC trainer or parents if they have any symptoms.
3. Keep the athlete out of play the day of the injury and until a medical provider, experienced in evaluating for concussion, says he or she is symptom-free and it's OK begin the to return to play protocol.

CONCUSSION CONSENT FORM

Athletes who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting the athlete for a lifetime.

SEEK MEDICAL CARE

Most athletes are treated in the emergency department or in a medical office by a licensed physician or PA after a concussion and return home. However, when the injury is more serious, the athlete may need to stay in the hospital overnight.

WHAT TO TELL THE MEDICAL PROVIDER

Be sure to tell the medical provider if the athlete is taking medications—prescription, over-the-counter medicines, or "natural remedies." When possible, also write down and share the following information:

- Cause of the injury and force of the hit or blow to the head or body
- Any loss of consciousness (passed out/knocked out) and if so, for how long
- Any memory loss right after the injury
- Any seizures right after the injury
- Number of previous concussions (if any)

PREVENTION

- The right equipment for the sport, worn correctly and the correct size and fit. Equipment worn every time the athlete practices or competes.
- Have parents who talk with athletes about concussion and model and expect safe play.
- Get written instructions from a health care provider on when to return to school and play.
- Support their teammates sitting out of play if they have concussion.
- Feel comfortable reporting symptoms of a possible concussion to coaches.

IF AN ATHLETE BELIEVES THEY MAY HAVE A CONCUSSION: DON'T HIDE IT. REPORT IT. TAKE TIME TO RECOVER.

I hereby acknowledge that I am familiar with the nature of the risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student- Athlete Signature_____ Date_____/_____/_____

I hereby acknowledge that I am familiar with the nature of the risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent /Guardian Signature _____ Date_____/_____/_____

REFERENCES

1. Centers for Disease Control and Prevention. (2015). CONCUSSION AT PLAY: Opportunities to Reshape the Culture Around Concussion. Atlanta, GA: U.S. Department of Health and Human Services.
2. PA Department of Health. (2016) Concussion Management , http://www.health.pa.gov/My%20Health/School%20Health/Pages/Quick%20Links/Special%20Concerns/Concussion-Management.aspx#.WPTpWPnyuM9

ANC

Completed Health Form must be returned at the same time as registration.

Questions? Call: 267-502-4582

ATHLETE/PARENT/GUARDIAN SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS INFORMATION SHEET AND ACKNOWLEDGEMENT OF RECEIPT AND REVIEW FORM

Please fill out this form and return to: **Doering Health Clinic, 2800 Buck Rd, Box 710, Bryn Athyn, PA 19009**

Student Name: _____ Date of Birth: _____ (Month) / _____ (Day) / _____ (Year) Gender: ❑ Male ❑ Female

FROM THE PENNSYLVANIA DEPARTMENT OF HEALTH

WHAT IS SUDDEN CARDIAC ARREST?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A student's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues.

SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

HOW COMMON IS SUDDEN CARDIAC ARREST IN THE UNITED STATES?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 students die of SCA each year. It is the #1 cause of death for student athletes.

ARE THERE WARNING SIGNS?

- fainting or seizures during exercise
- unexplained shortness of breath
- dizziness
- extreme fatigue
- chest pains
- racing heart

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

WHAT ARE THE RISKS OF PRACTICING OR PLAYING AFTER EXPERIENCING THESE SYMPTOMS?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

ACT 59 - THE SUDDEN CARDIAC ARREST PREVENTION ACT (THE ACT)

The act is intended to keep student-athletes safe while practicing or playing. The requirements of the act are:

- All student-athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may also hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses and athletic trainers.

ATHLETE/PARENT/GUARDIAN SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS INFORMATION SHEET AND ACKNOWLEDGEMENT OF RECEIPT AND REVIEW FORM

REMOVAL FROM PLAY/RETURN TO PLAY

- Any student-athlete who shows signs or symptoms of SCA must be removed from play. The symptoms can happen before, during or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

Student-Athlete Signature _____

Print Student-Athlete Name_____ **Date**_____/_____/_____

Parent /Guardian Signature _____

Print Parent/Guardian Name _____ **Date**_____/_____/_____