

# ANC

ACADEMY OF THE NEW CHURCH

**DEADLINE**  
The form must  
be submitted by  
**June 30, 2018**

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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, 2018** 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 determine 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: fill in below or provide a copy of Immunization Record from Healthcare Provider

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 (Diphtheria, Tetanus, Pertussis) or Tdap 4 doses				
*Required	Tdap booster - less than 5 years				
*Required	OPV/IPV (Polio) 3 doses				
*Required	MMR (Measles, Mumps, Rubella) 2 doses				
*Required	Hepatitis 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 I cannot be reached, I hereby give my consent for emergency treatment or non-emergency tests or diagnostics deemed necessary for above named ANC student according to the judgement of the attending physician, nurse, athletic trainer, and/or designee. I also give permission to the Doering Health Clinic and school physician (and /or his designees) to hospitalize and secure proper treatment for my son/daughter in case of a medical/surgical/dental/psychiatric emergency, provided they are unable to communicate with me and, if, according to their best professional judgement, further delay might jeopardize the welfare of my child. I agree to pay for physician and or surgical fees, hospital charges and related expenses for such emergency medical care. Furthermore, I understand any and all students may choose to check in with ANC counseling services as needed without parental consent. If the ANC counseling services deem ongoing therapeutic care is required, I will be involved in this decision.

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   | YES   | YES  | YES  |
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Chickenpox DATE: _____             | <input type="checkbox"/> Heat-related illness    | <input type="checkbox"/> Pertussis DATE: _____         |
| <input type="checkbox"/> Alcohol/drug abuse                 | <input type="checkbox"/> Crohn's disease/ulcerative colitis | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Positive tuberculin skin test |
| <input type="checkbox"/> Anxiety or panic attacks           | <input type="checkbox"/> Eating Disorder                    | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Sickle cell trait/disease     |
| <input type="checkbox"/> Asthma, including exercise induced | <input type="checkbox"/> Epilepsy/seizures                  | <input type="checkbox"/> Marfan's Syndrome       | <input type="checkbox"/> Thyroid condition             |
| <input type="checkbox"/> Attention Deficit Disorder         | <input type="checkbox"/> Fainting/blackouts                 | <input type="checkbox"/> Meningitis/encephalitis | <input type="checkbox"/> Urinary tract infection       |
| <input type="checkbox"/> Bee sting allergies                | <input type="checkbox"/> Food allergies                     | <input type="checkbox"/> Menstrual problems      | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Blood clotting disorder            | <input type="checkbox"/> Headaches, frequent or severe      | <input type="checkbox"/> Mononucleosis           |  |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Heart murmur, arrhythmia           | <input type="checkbox"/> Ovarian cyst            |  |

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  | YES  | YES                                      |
| <input type="checkbox"/> Blood clotting disorder | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Sudden death    |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Mental illness      |  |
| <input type="checkbox"/> Heart arrhythmia        | <input type="checkbox"/> Migraine            |  |

Student has my permission to participate in any physical activity or sport.  YES  NO

*I understand that there is potential risk for injury involved with any participation in physical activities, sports, and athletic contests. Unavoidable accidents could result in severe injury, paralysis, permanent mental disability or death. While these occurrence are rare, they do occur from time to time. I hereby accept these risks and give consent for my student to participate in all levels of physical activities, sports, and athletic contests.*

If no, please explain: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ 

**Permission for concussion testing:**

*I give my permission for the Certified Athletic Trainer to administer baseline testing for concussion, and deliver immediate and preventive care to my son or daughter. I understand all Sports Medicine Policies and Procedures for Return to Play from illness, injury, and concussion, and I am willing to abide by them.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ 

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**PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICINE:**

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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                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Acetaminophen: 325mg or 650mg tablets as needed for pain.<br>a. May repeat every 4-6 hours, not to exceed 6 tablets in 24 hours.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Ibuprofen: 200mg (1-2) tablets as needed for pain.<br>a. May repeat every 4 hours, not to exceed 6 tablets in 24 hours.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Sudanyl PE (phenylephrine): (1 or 2) 5mg tablets for sinus congestion<br>a. May repeat every 4-6 hours, not to exceed 6 tablets in 24 hours.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Loratadine: (1) 10mg tablet daily as needed for cold/allergy symptoms per directions on package.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Cough Drops   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Tums chewable: 2 tablets for indigestion, repeat as directed by manufacturer.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Loperamide HCL: 2mg caplets as needed for diarrhea.<br>a. Two caplets after first loose stool, then 1 caplet after subsequent loose stools, not to exceed 4 caplets in 24 hours.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Miralax 17g dissolving: Once a day according to package directions for constipation.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Homeopathic remedies as prescribed by camper's homeopathic practitioner.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Benadryl or generic equivalent: 25mg to 50mg capsules or liquid as needed for allergic reaction  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Epi-Pen auto injector: 0.3 mg as needed for acute allergic reaction.<br>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 licensed professional nurses 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, 2018 and August 1, 2018.*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The physical examination must be completed between May 1, 2018 and August 1, 2018. 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 Abnormal 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

I hereby certify that I have reviewed the health history, performed a comprehensive initial pre-participation physical evaluation of the herein named student except as specified below, this student is physically fit to participate in practice and athletic contests.

Health care provider signature \_\_\_\_\_ 

**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 international admission. Not required for low risk domestic students.*

Date: \_\_\_\_\_ Results:     Negative     Positive \_\_\_\_\_ mm. induration Chest X-ray result: \_\_\_\_\_

**Physician Signature: Must be signed!** 

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, 2018 and August 1, 2018)

Physician Signature: \_\_\_\_\_

Physician Full Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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## CONCUSSION CONSENT FORM

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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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female  
Month Day Year

### 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 to begin the to return to play protocol. Documentation **MUST** be provided to the Health Clinic or Athletic Trainer.

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## CONCUSSION CONSENT FORM

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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, PA, or nurse practitioner 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.
- Parents, coaches, athletic trainer, and school nurse who talk with athletes about concussion and model and expect safe play.

### 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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**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>

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

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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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female  
Month Day Year

### **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.

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

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**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** \_\_\_\_\_

**Parent /Guardian Signature** \_\_\_\_\_