ANNUAL
CONSENT FOR MEDICAL CARE
(Distributed to nurses' office, teachers, coaches, etc.)

This form must be completed in ink. Please print or type all information

Student's name ___________________________________ Grade ______________
Parent's/Guardian's Names ____
Legal Custody belongs to: Both parents ________ Other ___________

Local Emergency Contacts, complete all lines. Number by call priority.
___Parent, name _________ call this # 1st _________________ , 2nd #_________________
___Parent, name _________ – call this # 1st ________________, 2nd #__________________
___ Person to call if parent/guardian not available _____________Relationship ___________
Call this # 1st _____________, 2nd # _______________
___ Person to call if parent/guardian not available _____________Relationship ___________
Call this # 1st _____________ , 2nd # ________________

Student's Health Insurance. If none, state none. _____________________________________
Policy Number ______________________Insurance phone # _________________________

List all food allergies and reactions. If none, state, none. ______________________________
List other allergies (including drug allergies). If none, state none. _______________________
Identify health concerns. If none, state none. _______________________________________
List all current medications. If none, state none. _____________________________________

If my child is not feeling well during the school day, the school nurse or faculty member if the nurse is not available has parent permission to give over-the-counter medication, as appropriate, to my child according to the labeled instructions. Please initial.
Yes ______________ No _____________

For the school year, in the case of a health emergency, the school is authorized to call 911 and/or utilize the nearest emergency room. The doctor in attendance has my permission to proceed with any critical medical treatment required for my student. The school will make every attempt to contact the parent or guardian in the event of an emergency. The parent assumes full financial responsibility for any emergency care. Please initial.
Yes _____________ No _____________

The above information is considered confidential. With the signatures below, families consent to the release of the above information on a need-to-know basis. Parent(s)/guardian(s) should sign below:

Parent/guardian signature _________________________ Date ____________________

THE COLORADO SPRINGS SCHOOL

ANNUAL PHYSICAL EXAM FORM

To be completed by a parent/guardian. Please print all information.

Student ____________________________________ Date of Birth ____________________ Grade ______________________

Please circle gender: male female

MEDICAL HISTORY

Allergies ____________________________Food allergy ______________________ Illness ___________________________

Surgeries ____ Accident/ Injury ______________________________

Is student taking **any** medication on a routine basis? Yes _____ No _____

List all medication :____

Is student allergic to any medication? Yes _____ No _____ Please list and describe reaction:

____

Has student consulted with a specialist in the past 5 years?

Yes _____No _____ If yes, please describe nature of condition:____

This section to be completed by examining physician.

PHYSICIAN EXAMINATION :

Height_________ Weight ___________ BMI _______ Blood Pressure_____________ Pulse ______________

	Normal	Abnormal		Normal	Abnormal
General Appearance			Cardiovascular		
Skin			Gastrointestinal		
Eyes			Genito-urinary		
Ears/Nose/Throat			Neurological		
Mouth/Dental Assessment			Developmental Screening		
Muscular			Nutritional Assessment		
Skeletal			Respiratory		

Are there concerns for this student's health?

____

Is the student capable of physical activity and participation in a competitive athletic program? ______Yes ______No

Are there any sports in which this student should not participate?____

Are there any restrictions or activity limitations?____

SCREENING TESTS:

Tuberculin test: Date ______________ Positive ______Negative _______ CSR date (if pos.): ____________

Vision: Right 20/________ Corrected to 20/_________ Left 20/__________ Corrected to 20/_______________

RECENT IMMUNIZATION DATES:

Varicella: dose one _______________, dose two _______________ History of the disease: ______________

Td/Dtap: ________ MMR: ______ HEP B: _______, _______, _______ Polio: _____ HEP A _____, ______

Prevnar (PCV7) pneumonia _____________

Results of the physical exam completed by me on this date indicate that the individual named above is in good health. Any problems to the contrary have been noted above.

Date _________________ Examining Physician Signature ____

Physician's Name ____________________ ______________________________Phone ______________