Health Form Requirement Checklist

Please do not submit your child’s health form without first completing the following steps:

Parent - Page 1
- Complete entire page 1
- Sign and date the bottom of the parent page.

Doctors - Page 2
- Physician must complete and sign, date, and stamp page 2
  OR
- Attach pediatrician’s customized medical form AND doctor must sign, date, and stamp the Packer form.
- **Doctor must sign, date, and stamp the Packer form**, regardless of doctor’s office use of customized medical report.

Parent and Doctors - Page 3 (7th – 12th Grades)
- Parent and doctor must sign the **Off-Campus Self-Medication Release Form** for students to carry and self medicate when traveling off campus with Packer.

**ONLY** if your child has food, insect, or other **SEVERE allergies** and/or a prescription for emergency epinephrine injections for severe allergies, you must also submit the **Severe Allergy Treatment Plan** form.

Parent
- Fill out all student and family information.
- Must include a recent photo of your child.
- **Sign and date the bottom of the page.**

Doctors
- Complete the medical portions of the form. **Doctor must sign, date, and stamp the Packer form.**

**Before Submitting Your Health Form**
- Please ensure that the form is complete. **Please do not submit partial or unsigned forms.**
- Make copies of all documents for your own personal records.
- Mail, email, fax, or deliver health form directly to the Nursing Office.
Parents please complete and sign this page. Physicians must sign and stamp page two.

### Consent for Emergency Medical Treatment

I authorize The Packer Collegiate Institute nurse and delegated staff to obtain emergency treatment for my child. I expect family and/or contact individuals to be contacted either immediately or as soon as possible regarding emergency interventions. I permit the nurse and staff to care for my child if he/she becomes ill or injured either during the school year or during summer programs. I permit the nurse to contact my child’s health care providers for medical instructions, for health form information updates and to report a medical/injury occurrence.

### Medication

- [ ] No Do not administer medication to my child.
- [ ] Yes You may administer the following medications:
  - [ ] PRESCRIBED MEDICATION (MUST BE ACCOMPANIED BY A DOCTOR’S PRESCRIPTION, INCLUDING DECONGESTANTS/SUPPRESSANTS)
  - [ ] ACETAMINOPHEN (E.G. TYLENOL®)
  - [ ] ANTIBIOTIC OINTMENT
  - [ ] ANTIHISTAMINE (E.G. CLARITIN®, BENADRYL®, ETC.)
  - [ ] IBUPROFEN
  - [ ] SUNBLOCK
  - [ ] ANTACID (TUMS®, MYLANTA®)
  - [ ] ANTIEMETIC (E.G. DRAMAMINE®)
  - [ ] TOPICAL CORTISONE

### Emergency Contact Information

The persons listed here may pick up my child.

<table>
<thead>
<tr>
<th>PARENT OR GUARDIAN NAME</th>
<th>CELL PHONE</th>
<th>WORK PHONE</th>
<th>EMAIL</th>
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<tr>
<th>EMERGENCY CONTACT NAME &amp; RELATIONSHIP</th>
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<th>WORK PHONE</th>
<th>EMAIL</th>
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Parent/Guardian Signature is required below. Please notify the nursing office immediately of any changes in contact information. Thank you.

<table>
<thead>
<tr>
<th>PARENT OR GUARDIAN SIGNATURE</th>
<th>DATE</th>
<th>RELATIONSHIP</th>
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Please sign!
MEDICAL FORM page two

PHYSICIAN’S REPORT

STUDENT’S NAME

GRADE DOB

History

DATE OF ONSET

Required Screenings

DATE RESULT

ASTHMA

LEAD (0-10)

PRE-K REQUIREMENT

DIABETES

HCT/HG

LIGAMENT/SKELETAL

BODY MASS INDEX

SURGERY

SCOLIOSIS

ATTENTION ISSUES

MANTOUX

OTHER (specify)

REACTIVE MANTOUX

CHEST X-RAY REQUIRED

HEARING

VISION

Physical Examination

DATE OF EXAM

MEDICATIONS

PHYSICIANS MUST LIST ALL
PRESCRIPTION MEDICATIONS

HEALTH, WEIGHT

BLOOD PRESSURE, PULSE

MEDICAL FINDINGS/DIAGNOSES

Allergies

INCLUDING FOOD, MEDICATION,
SEASONAL, ANIMAL & INSECT

Treatment Instructions and Medical Approval

Treatment instructions:

The student named above may participate fully in school activities. I grant approval for medication administration, following standardized doses for weight and age.

PRINT HEALTH PROVIDER’S NAME

TELEPHONE

FAX

SIGNATURE

DATE

Immunizations

REQUIRED

DPT 1st

DPT 2nd

DPT 3rd

DPT 4th

DPT booster

Tdap

OPV/IPV 1st

OPV/IPV 2nd

OPV/IPV 3rd

OPV/IPV 4th

MMR 1st

MMR 2nd

HIB 1st

HIB 2nd

HIB 3rd

HIB 4th

Varicella 1st

Varicella 2nd

Hep B 1st

Hep B 2nd

Hep B 3rd

PCV complete

YES NO

RECOMMENDED

HPV 1st

HPV 2nd

HPV 3rd

Hep A 1st

Hep A 2nd

Meningococcal

Flu

PACKER MEDICAL FORM

Physician’s/Providers stamp must be included here

Nursing Office:
Fax: 718 250-0292

PAGE 2
Off-Campus Self-Medication Release Form
Permission to self administer medication when traveling with Packer

When traveling off campus with Packer, including Packer overnight trips and Packer athletic events,
we (parent and physician) declare that _______________________________ , 7 8 9 10 11 12, (student name) (grade: circle one)
is self directed; and we give permission for her/him to carry and self-administer OTC and prescription* medications that have been pre-approved on the Packer Health Form. A copy of the prescription will be provided to the Nurse’s Office, and the medication will be kept in a properly labeled original prescription bottle. ________________________________ will be instructed in and understand the purpose (student name) and appropriate method and frequency of use of the medication(s).

*Students are never permitted to carry and self administer stimulant medication, including Ritalin, Concerta, Adderall, Dexedrine, Focalin, Metadate, Vyvanse, etc.

Parent or guardian signature:__________________________________________ Date:______________

Physician signature:________________________________________________ Date:_______________