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.

MEDICAL FORM

STUDENT LAST NAME  FIRST NAME  MIDDLE NAME

STREET ADDRESS

CITY, STATE, ZIP

HOME PHONE

LIST ALL PRESCRIBED MEDICATIONS (DAILY, EMERGENCY, AND AS-NEEDED)

LIST ALL ALLERGIES AND REACTIONS AND MEDICATIONS, INCLUDING EYE DROPS

LIST ALL HEALTH CONDITIONS/ MEDICAL AND SURGICAL HISTORY

LIST ALL NUTRITION/DIETARY ISSUES

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

☐ ANTHISTAMINE (E.G. CLARITIN®, BENADRYL®, ETC.)

☐ IBUPROFEN

☐ SUNBLOCK

☐ ANTACID (TUMS®, MYLANTA®)

☐ ANTIEMETIC (E.G. DRAMAMINE®)

☐ TOPICAL CORTISONE

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.

Packer’s Paperwork Reduction Act

This single form authorizes treatments on- and off-campus as well as overnight trips.

Dental Information

DENTIST

TELEPHONE

ORTHODONTIST

TELEPHONE

Emergency Contact Information  The persons listed here may pick up my child.

PARENT OR GUARDIAN NAME  CELL PHONE  WORK PHONE  EMAIL

PARENT OR GUARDIAN NAME  CELL PHONE  WORK PHONE  EMAIL

EMERGENCY CONTACT NAME & RELATIONSHIP  CELL PHONE  WORK PHONE  EMAIL

Parent/Guardian Signature is required below. Please notify the nursing office immediately of any changes in contact information. Thank you.

PARENT OR GUARDIAN SIGNATURE  DATE  RELATIONSHIP

Please sign!
## 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

**Recommended**
- HPV 1st
- HPV 2nd
- HPV 3rd
- Hep A 1st
- Hep A 2nd
- Meningococcal
- Flu

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### History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date of Onset</th>
<th>Required Screenings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td>Lead (0-10)</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>HCT/HGB</td>
</tr>
<tr>
<td>Ligament/Skeletal</td>
<td></td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Attention Issues</td>
<td></td>
<td>MANTOUX</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td>Reactive MANTOUX</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest X-ray Required</td>
</tr>
</tbody>
</table>

### Physical Examination

**DATE OF EXAM**
- Height, weight
- Blood pressure, pulse
- Medical findings/diagnoses

**Medications**

**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**

**PHONE**

**FAX**

**SIGNATURE**

**DATE**

**PHYSICIAN'S PROVIDER'S STAMP MUST BE INCLUDED HERE**
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:_______________