St. Andrew's School
350 Noxontown Road
Middletown, DE 19709-1605

Health Center

2019-2020 Health Form Requirements & Information for New Students

Dear Parents/Guardians:

Your child's health is important to us! The information that you provide in the Health Forms each school year is essential for helping the health care staff care for your child. In the event that your child would need medical attention, our healthcare providers would rely on this information to treat your child.

Before you begin the process of filling out the required Health Forms, please take some time to review the information on the Health Center section of the website pertaining to allergies, prescription medication, insurance and other important information.

Please complete the 2-step process for our health forms.

Step 1. By May 1, answer the required questions via Google Health Form Questionnaire.

Step 2. By June 30, download, print, and complete the required health forms for your NEW student.

The Health Forms must be completed on or after April 1, 2019 and a physical examination is required after June 30, 2018 according to the Delaware Interscholastic Athletic Association (DIAA). Please note that the DIAA requires the signature of the healthcare provider, student/athlete, and the parent/guardian. Even if the student is not participating in sports, you must still complete and sign the DIAA forms.

Please take a few minutes to review the checklist before submitting the Health Forms to us via email, fax or mail. Please be aware that if we receive the forms via email or fax and they are not legible, we will require the hard copy be sent via mail.

DEADLINE FOR 2-STEP PROCESS OF HEALTH FORMS

MAY 1, 2019 — Step 1 (Questionnaire)

June 30, 2019 — Step 2 (Forms)

HEALTH CENTER
St. Andrew's School
350 Noxontown Road
Middletown, DE 19709
fax: 302-378-8512
email: healthcenter@standrews-de.org

During the summer, while our Health Center is closed, a member of our health services staff will be in the office at least once a week to check messages and emails. If you have any questions or concerns, please feel free to contact us at 302-285-4240 or at healthcenter@standrews-de.org.

We look forward to seeing you on Opening Day in Founders Hall. Please be sure to check in with us to verify that your child's health forms are complete, and bring all (prescription and over-the-counter) medications your child has brought to school. **Medications (prescription and over-the-counter) are NOT permitted on dorm unless approved by the Health Center.**

St. Andrew's School
350 Noxontown Road
Middletown, DE 19709-1605

Health Center

Guidelines for the Athletic Program

REQUIREMENTS

1. **The Health Forms must be completed on or after April 1, 2019 and a physical examination is required by ALL students after June 30, 2018, according to the Delaware Interscholastic Athletic Association (DIAA).**
2. Interscholastic sports are a core part of our co-curricular education. III and IV Form students are required to play a minimum of 2 sports during each school year and V and VI Form students are required to play a minimum of 1 sport during each school year. Because of this requirement, all students must complete the attached forms required by the Delaware Interscholastic Athletic Association (DIAA). **These forms must be on file with our Health Center staff before a student is permitted to participate in sports.**
3. Prior to the students' physical examination, the parent/guardian and student should complete and sign all applicable forms. **During or after the physical examination, your physician or healthcare provider must complete and sign the applicable DIAA and health forms.**
4. If the health forms are incomplete or are not on file, for whatever reason, the student will **NOT be allowed to participate in sports and may NOT be permitted to reside on campus**.

Health Forms for ALL students must be sent to the Health Center by:

June 30, 2019

PLEASE DO NOT WAIT UNTIL THE STUDENT ARRIVES ON CAMPUS TO HAND IN THE FORMS.

(The Health Center has to review, scan, and upload all health forms prior to the start of school.)

EXPECTATIONS

There are two expectations concerning attendance at games and practices:

1. We emphasize to our student-athletes the importance of making a commitment to the teams on which they play. We expect all team members to be at all games and practices unless there is an unusual family obligation such as a wedding, funeral or an emergency. Please do not request your child(ren) to miss games for family weekends. Coaches would appreciate any college visits to be completed during the summer or during breaks.
2. We have high expectations for our players in terms of training rules. Players are not to use alcohol, tobacco, or drugs in any form. We ask parents to support us in these matters and help protect your children from involvement with these substances. Violations will consist of some action by the School. We encourage athletes, at all levels, to eat properly, get sufficient rest and exercise good sportsmanship at all times.

EXERCISING

We highly recommend and encourage students to exercise during August to prepare them for the fall season. The demands for varsity athletes, as well as the JV and 3rd level teams, are such that it is important to prepare physically before arriving at St. Andrew's. ***We emphasize the importance of returning in good physical condition.***

If you have any questions, please contact:

Al Wood	Heidi Pearce	Health Center
Director of Boys Athletics	*Director of Girls Athletics*	302-285-4240
302-285-4246	302-285-4350	healthcenter@standrews-de.org
awood@standrews-de.org	hpearce@standrews-de.org	

St. Andrew's School
350 Noxontown Road
Middletown, Delaware 19709-8512
Phone 302-285-4240 Fax 302-378-8512
E-mail: healthcenter@standrews-de.org

This form must be completed by the parent or guardian.

STUDENT INFORMATION AND MEDICAL AUTHORIZATION

ALLERGIES: Parents/Guardians: please list ALL allergies below:

If the student is not allergic to anything, please check this box. ☐

☐ **medication allergies:** _____

☐ **food allergies:** _____

☐ **seasonal allergies:** _____ ☐ **other allergies:** _____

Student's Name _____ Gender: male ☐ female ☐
(first / middle / last)

Graduation Year: _____ Student Status: ☐ New ☐ Returning Present Age: _____ Birth Date: _____

Student resides with: ☐ Both parents ☐ Father ☐ Mother ☐ Other: _____

Mother	Father
Birth Date	Birth Date
Language Preference (if not english)	Language Preference (if not english)
Address	Address
Home Phone	Home Phone
Business Phone	Business Phone
Cell Phone	Cell Phone
E-mail Address	E-mail Address

If status is other than "Married," please check all that apply to status of parents:
☐ *Separated* ☐ *Divorced* ☐ *Both parents have custody* ☐ *Only Mother has custody* ☐ *Only Father has custody*

Alternative responsible person to be reached in case of emergency if parent/guardian is unavailable:

Name _____ Relationship to Student _____

Home Address _____

Home Phone _____ Cell Phone _____

E-mail Address _____ Business Phone _____

Medical Treatment/Emergency Treatment Release:

I hereby authorize St. Andrew's School and its agents or representatives to consent on my behalf to any medical or hospital care or treatment (including at locations outside of the United States) to be rendered to the student upon the advice of any licensed physician. I also give my permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures rendered pursuant to this authorization. I agree to be responsible for all charges incurred in connection with any medical treatment rendered pursuant to this authorization. Transportation charges may be incurred in regards to delivery of care.

Further, I hereby grant permission to St. Andrew's School to release any health information pertaining to the student to facilitate diagnosis, care, treatment or insurance claims. In addition, I authorize St. Andrew's School to release any information pertaining to the above-named alternative responsible person, as well as the following individuals: _____

and to discuss such information with any of these individuals to the extent necessary to facilitate the student's medical treatment or care.

I give permission for the school nurse and my child's primary care physician _____ to share information relating to these health forms.
(Name of Physician)

It is understood that this permission is valid as long as the student is enrolled at St. Andrew's School.

I certify that all information submitted on all health forms is factually accurate and honestly presented. (The student may be dismissed if the information you have certified is found to be false.).

➡ **X** _____ _____
Signature of Parent or Guardian — Date

St. Andrew's School
350 Noxontown Road
Middletown, Delaware 19709-8512
Phone 302-285-4240 Fax 302-378-8512
E-mail: healthcenter@standrews-de.org

THIS FORM MUST BE COMPLETED BY THE PARENT/GUARDIAN AND RETURNED WITH THE HEALTH CENTER FORMS.

HEALTH & ACCIDENT INSURANCE FOR 2019/2020

If your child is covered under your primary health insurance and you do NOT wish to purchase additional health or accident insurance, which is listed at the bottom of this page, please fill out the following information. (Please note: **ALL** international students are **required** to purchase Plan I insurance through St. Andrew's School. Please complete the bottom of this page.)

☐ **Is your primary insurance a Medicaid Insurance Plan? ☐ Yes ☐ No**

☐ **I do NOT wish to enroll** _____ in Plan I listed below because my child is
CHILD'S NAME
covered under my primary insurance. I accept full responsibility for all medical costs incurred by my child.

➡ **X** _____ _____
SIGNATURE OF PARENT OR GUARDIAN — DATE

Parent/Guardian: Please provide child's name and check the appropriate box(es) below.

You must return this form (along with your child's health forms) to the Health Center. Those who enroll in any of these plans will be billed through Smart Tuition.

☐ **Please enroll** _____ **in:** *(check appropriate boxes below)*
CHILD'S NAME

***Plan I: Student Health Insurance (International Students Only)**
Underwritten by United Healthcare Insurance Co.

****All international students are required to purchase Plan 1.***

☐ 10 months (8/15/19–6/14/20) for $1,880.00 (international students only)

Plan II: <u>Optional</u> Student Accident Insurance
Underwritten by A.W.G. Dewar, Inc.

☐ 10 months (8/23/19–5/30/20) for $120.00

Does your child have a social security number (SSN)? ☐ Yes** ☐ No

**Please provide SSN _ _ _ - _ _ - _ _ _ _ for your child's claim form.

Note: Details about these plans are available on St. Andrew's website.

If purchasing Plan I insurance through St. Andrew's School, the Health Center will complete the health insurance information that is required on Page HCF-3; however, **the parent/guardian is responsible for completing the "Care Provider Information"** at the bottom of that page.

Please note that the insurance cards for Plan I will be mailed directly to the student at St. Andrew's School in October. As a courtesy, the Health Center will send a copy of the insurance card to the parent/guardian.

➡ **X** _____ _____
SIGNATURE OF PARENT OR GUARDIAN — DATE

For Office Use Only:
HC Rec'd: _____ Entered into ST: _____

INSURANCE INFORMATION

(Parents/Guardians: Please provide this information unless you are purchasing insurance through St. Andrew's.)

Student Name: _____

PRIMARY HEALTH INSURANCE COVERAGE: ***Must include an ENLARGED copy of the FRONT & BACK of insurance card.***

INSURANCE COMPANY _____

NAME OF POLICY HOLDER_____ BIRTHDATE OF POLICY HOLDER_____

GUARANTOR (name of Parent/Guardian responsible for payment) _____

GROUP#/NAME_____

ID#/POLICY# _____ SS# OF POLICY HOLDER __ __ __ - __ __ - __ __ __ __

INSURANCE CO. ADDRESS_____

INSURANCE CO. PHONE _____

IS THIS INSURANCE PLAN A: ☐ PPO ☐ HMO ☐ MEDICAID ☐ OTHER _____

ARE REFERRALS REQUIRED? (Please check with your insurance company.) YES ☐ NO ☐

OUT-OF-NETWORK COVERAGE OR AWAY FROM HOME COVERAGE? YES ☐ NO ☐ *(please check with your insurance company)*

DOES YOUR POLICY INCLUDE PRESCRIPTION COVERAGE? YES ☐ NO ☐ COPAY? _____
(Must include an ENLARGED copy of the FRONT AND BACK of prescription drug card)

PRESCRIPTION ID/ACCOUNT #: _____ Rx BIN # _____ PCN #_____ GRP#_____

COMPANY THAT ADMINISTERS PRESCRIPTION COVERAGE:_____ PHONE:_____

Please provide an ENLARGED copy of the FRONT and BACK of <u>ALL</u> insurance cards (health, dental and prescription) for the student.

An enlarged copy of these cards is REQUIRED.

Thank you!

DENTAL INSURANCE COVERAGE: ***Must include an ENLARGED copy of the FRONT & BACK of insurance card.***

INSURANCE COMPANY _____

POLICY#_____ GROUP#_____ ID# _____

INSURANCE CO. ADDRESS_____

INSURANCE CO. PHONE _____

CARE PROVIDER INFORMATION *(Parents/Guardians: Please provide this information.)*

HEALTH CARE PROVIDER:

PHYSICIAN _____

PHYSICIAN'S FULL ADDRESS _____

PHYSICIAN'S OFFICE PHONE_____ FAX (if available) _____

DENTAL CARE PROVIDER:

DENTIST _____

DENTIST'S FULL ADDRESS _____

DENTIST'S OFFICE PHONE_____ FAX (if available) _____

CONFIDENTIAL MEDICAL HISTORY RECORD (New Students)

This confidential information is strictly for the use of the Health Center in providing necessary health care while your son/daughter is a student at St. Andrew's School. This is to be filled out by the student and parent, and reviewed by your physician.

STUDENT NAME: _____ **DOB:** _____

FAMILY HISTORY: Have family members ever had any of the following:

- ☐ Diabetes
- ☐ Gastrointestinal Disease
- ☐ Kidney Disease
- ☐ Epilepsy/Seizures
- ☐ Mental Health
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Allergies/Hay Fever

On the lines below, please explain the relationship to the student for these conditions (or other conditions). _____

_____

_____

PERSONAL HISTORY: All questions must be answered.

Please comment on all "yes" answers in space provided or on an additional sheet.

	YES	NO	EXPLANATION/DATE
Have you had headaches or migraines?	☐	☐	_____
Do you currently have dental braces, bridges or plates?	☐	☐	_____
Have you had rheumatic fever?	☐	☐	_____
Have you had ulcers, colitis, irritable bowel syndrome or stomach aches?	☐	☐	_____
Have you ever had urinary tract infections, kidney disease or bedwetting?	☐	☐	_____
Have you ever had problems with sleeping?	☐	☐	_____
Are you ever tearful or sad? (If yes, what causes it?)	☐	☐	_____
Have you ever been treated for emotional problems, depression or anxiety?	☐	☐	_____
Have you ever been tested or diagnosed with ADD, ADHD or other learning differences?	☐	☐	_____
Do you take medication for ADD, ADHD or other learning differences?	☐	☐	_____

List the things that cause you stress. _____

What other information can you provide about your child that would be helpful/useful for the Health Center to know in order to treat him/her? _____

_____

I certify that all information submitted on this form is factually accurate and honestly presented.

➡ **X** _____ _____
SIGNATURE OF PARENT/GUARDIAN — DATE

➡ **X** _____ _____
SIGNATURE OF STUDENT — DATE

IMMUNIZATION HISTORY

All **new** and **transfer** students **must meet** the following immunization requirements for school attendance according to the Delaware Division of Public Health:

- 1 dose of **Tdap Vaccine**
- 3 or more doses of **DTP** or **DTaP** or **DT Vaccine**
- 3 or 4 doses of **Polio Vaccine** (last dose after the 4th birthday)
- 2 doses of **MMR (Measles, Mumps, Rubella) Vaccine** (or equivalent)
  (1st dose given 12 months of age or later;
  2nd dose given at least 1 month after 1st dose)
- 3 doses of **Hepatitis B Vaccine**
- 2 doses of **Varicella Vaccine** (unless provider documented history of chicken pox or titers)
- 1 dose of **Meningococcal Vaccine**

Recommended (not required)

- 2 doses of **Hepatitis A Vaccine**
- 2 doses of **Meningococcal Vaccine (ACWY)**
- 2 or 3 doses of **HPV (Human Papillomavirus) Vaccine** (dependent on administration of 1st dose)

Please provide a copy of the student's immunization record from their doctor's office, which should include the month, day and year that the student received their vaccines.

Please be sure that the student has received ALL immunizations (as listed above) as REQUIRED by the State of Delaware Division of Public Health.

NEW STUDENTS ONLY

MEDICAL PROVIDER: Please COMPLETE and SIGN this form.

REQUIRED Tuberculosis (TB) TESTING

(Regardless of receiving a BCG Vaccine as an infant)

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

Has student ever had a positive tuberculosis (TB) skin test or blood test in the past? ☐ No* ☐ Yes**
*If the answer is "NO", please refer to Section A. **If the answer is "YES", please refer to Section B.

SECTION A – If you answered "NO" to the above question, a PPD skin test is <u>required</u> between September 1, 2018 and August 31, 2019.

PPD Date Placed _____ Date Read _____ Results _____ mm

If the results are >10 mm of induration, it is considered POSITIVE. If it is POSITIVE, a Quantiferon Assay is REQUIRED.

Quantiferon Assay Date _____ Results of Quantiferon Assay _____

_____

Follow Up Testing, if applicable (repeat Quantiferon Assay or Chest X-ray): _____

_____

Medication (if ordered): _____

Date Started _____ Date to Be Completed _____

➡ **X** _____ _____
SIGNATURE OF MEDICAL PROVIDER DATE

SECTION B – If you answered **"YES"** to the above question, **a Quantiferon Assay is <u>required</u> between September 1, 2018 and August 31, 2019.**

If student has tested positive in the past, please specify date (month and year) _____.

Quantiferon Assay Date _____ Results of Quantiferon Assay _____

_____

Follow Up Testing, if applicable (repeat Quantiferon Assay or Chest X-ray): _____

_____

Medication (if ordered): _____

Date Started _____ Date to Be Completed _____

➡ **X** _____ _____
SIGNATURE OF MEDICAL PROVIDER DATE

Delaware Interscholastic Athletic Association
Parent/ Player Concussion Information Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

Headaches	Pressure in head	Nausea or vomiting
Neck pain	Balance problems	Dizziness
Disturbed vision	Light/noise sensitivity	Sluggish
Feeling foggy	Drowsiness	Changes in sleep
Amnesia	"Don't feel right"	Low energy
Sadness	Nervousness	Irritability
Confusion	Repeating questions	Concentration problems

Signs observed by teammates, parents and coaches may include:

Appears dazed	Vacant facial expression
Confused about assignment	Forgets plays
Unsure of game/score etc	Clumsy
Responds slowly	Personality changes
Seizures	Behavior changes
Loss of consciousness	Uncoordinated
Can't recall events before or after hit	

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for the student-athlete's safety.

If you think your child has suffered a concussion:

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. You should also inform your child's coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information from the CDC on concussions you can go to:
https://www.cdc.gov/headsup/youthsports/index.html
For a current update of DIAA policies and procedures on concussions you can go to:
http://www.doe.k12.de.us/Page/3298
For a free online video on concussions you can go to:
https://nfhslearn.com/courses/61064/concussion-in-sports

All parents and players must sign the signature portion of the DIAA PPE indicating they have read and understand the above.

Adapted from the KHSAA, CDC and 3rd International Conference on Concussion in Sport, 4/2011

SUDDEN CARDIAC ARREST AWARENESS FORM

Revised 2018

What is Sudden Cardiac Arrest?

- An electrical malfunction (short-circuit) causes the bottom chamber of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- Occurs suddenly and often without warning
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated.

What causes Sudden Cardiac Arrest?

- Conditions present at birth (inherited and non-inherited heart abnormalities)
- A blow to the chest (Commotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
- Recreational/Performance-Enhancing drug use.
- Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The DIAA *Pre-Participation Physical Evaluation – Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.**
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find additional information?

- Contact your primary care physician
- American Heart Association (www.heart.org)
- August Heart (www.augustheart.org)
- Championship Hearts Foundation (www.championshipheartsfoundation.org)
- Cypress ECG Project (www.cypressecgproject.org)
- Parent Heart Watch (www.parentheartwatch.com)

Delaware Interscholastic Athletic Association

Pre-Participation Physical Evaluation

Parents/Guardians: The DIAA pre-participation physical evaluation and consents form consists of seven pages. Pages 1, 2 and 4 require your signature while pages 5, 6 and 7 are references for you to keep. Page 3 requires the exam date and phyisician's signature. Pages 3 and 4 require the clearance to participate date and physician's signature. The student must be cleared to participate on or after April 1st based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30th of the following school year.

NAME OF ATHLETE: _____ PHONE: _____ SCHOOL: ST. ANDREW'S SCHOOL _____

GRADE: _____ AGE: _____ GENDER: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN NAME: (PLEASE PRINT) _____

PARENT/GUARDIAN/STUDENT CONSENTS

_____ has my permission to participate in all interscholastic sports **NOT** checked below.
(Name of Athlete)

Note: If you check any sport below, the athlete will NOT be permitted to participate in that sport.

___ baseball	___ basketball	___ cheerleading	___ cross country	___ crew
___ field hockey	___ football	___ golf	___ ice hockey	___ boys lacrosse
___ girls lacrosse	___ soccer	___ softball	___ squash	___ swimming
___ tennis	___ track	___ volleyball	___ wrestling	

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the **Parent/Player Concussion Information Form**; **Symptoms and Risk Factor for Sudden Cardiac Arrest Form**; and the list of items that protect against the loss of athletic eligibility, with said participant and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics.

   I waive any claim for injury or damage incurred by said participant while participating in the activities NOT checked above.

   ➡ Parent Signature: X _____ Date: _____

   ➡ Student Signature: X _____ Date: _____

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

   ➡ Parent Signature: X _____ Date: _____

3. I further consent to DIAA's and its full and associate member schools' use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

   ➡ Parent Signature: X _____ Date: _____

4. By this signature, I hereby consent to allow the physician(s) and other health care providers(s) selected by myself or the schools to perform pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

   ➡ Parent Signature: X _____ Date: _____

5. **By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.**

   ➡ Parent Signature: X _____ Date: _____

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete X _____ Signature of parent/guardian X _____ Date _____

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Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP _____ / _____ (_____ / _____) Pulse _____	Vision R 20/ _____	L 20/ _____ Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Health Care Provider: Print/type Name _____ **Signature X** _____, MD, DO, PA, or NP

Address _____ Phone _____

Date of Exam: _____ Date Cleared to Participate: _____

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DIAA School Athlete Medical Card

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: Contact/Personal Information

Name: _____ Sport(s): _____

Age: _____ Grade: _____ Birth Date: _____ Guardian Name: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____ (P) _____

Other authorized person to contact in case of emergency:

Name: _____ Phone(s): _____

Name: _____ Phone(s): _____

Preference of Physician (and permission to contact if needed):

Name: _____ Phone(s): _____

Hospital Preference: _____ Insurance: _____

Policy #: _____ Group: _____ Phone: _____

Section 2: Medical Information

Medical Illnesses: _____

Last Tetanus (mo/yr): _____ Allergies: _____

Medications: _____

(any medications that may be taken during competition require a physician's note)

Previous Head/Neck/Back Injury: _____

Heat Disorder or Sickle Cell Trait: _____

Previous Significant Injuries: _____

Any Other Important Medical Information: _____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of the information as long as the information does not personally identify my child.

➡ Parent/Guardian Signature: X _____ Date: _____

➡ Athlete's Signature: X _____ Date: _____

Section 4: Clearance for Participation

_____ Cleared without restrictions _____ Cleared with the following restrictions: _____

➡ Health Care Provider's Signature: X _____ MD/DO,PA,NP Date: _____

For office use only: This card is valid from **April 1, 2018** through **June 30, 2019.**

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: **St. Andrew's School** ***Name of ATC:*** **Al Wood**

Asthma Patient Action Plan

2019-2020

Student _____

Cell Phone _____

Parent/Guardian _____

Cell Phone _____

Physician _____

Phone _____

Personal Best Peak Flow _____

You can use the colors of a traffic light to help you learn about your asthma medicines.

1. **Green** means **Go**.
   80-100% Personal Best Peak Flow.
   Use controller medicine.
2. **Yellow** means **Caution**.
   50-79% Personal Best Peak Flow.
   Use reliever medicine.
3. **Red** means **Stop**.
   <50% Personal Best Peak Flow.
   Get help from a doctor.

1. Green — Go

Symptoms

- ■ Breathing is easy
- ■ No coughing
- ■ No wheezing
- ■ No shortness of breath
- ■ Can work, play and sleep easily
- ■ Using quick-relief medication less than twice a week
- ■ **PEAK FLOW**
  80% – 100% of personal best
  _____ – _____

Control Medications:

Medicine	How Much to Take	When to Take It

10-20 minutes before sports or other strenuous activity, use this medicine:

_____

2. Yellow — Caution

Symptoms

- ■ Using quick-relief medication more than twice a week*
- ■ Coughing
- ■ Wheezing
- ■ Shortness of breath
- ■ Difficulty with physical activity
- ■ Waking at night
- ■ Tightness in chest
- ■ **PEAK FLOW**
  50% – 80% of personal best
  _____ – _____

** You might need a change in your treatment plan.*

Take reliever medicine to keep an asthma attack from getting bad.

Medicine	How Much to Take	When to Take It

2. Red — Stop — Danger

Symptoms

- ■ Medication is not helping
- ■ Breathing is very difficult
- ■ Cannot walk or play
- ■ Cannot talk easily
- ■ **PEAK FLOW**
  less than 50% of personal best
  _____

Get help from a doctor now! Take these medicines until you talk with the doctor.

Medicine	How Much to Take	When to Take It

If your symptoms do not improve and you cannot contact your doctor, go to the emergency room or call 911 immediately.

➡ X _____ PHYSICIAN SIGNATURE

DATE _____

➡ X _____ STUDENT SIGNATURE

DATE _____

➡ X _____ PARENT/GUARDIAN SIGNATURE

DATE _____

EPILEPSY FOUNDATION® Not another moment lost to seizures® epilepsy therapy project

STRONGER TOGETHER

2019-2020

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol

(Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

- Convulsive tonic-clonic seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

➡ X **Physician Signature** _____ **Date** _____

➡ X **Parent/Guardian Signature** _____ **Date** _____

➡ X **Student Signature** _____ **Date** _____

St. Andrew's School
350 Noxontown Road
Middletown, Delaware 19709-8512
Phone 302-285-4240 Fax 302-378-8512
E-mail: healthcenter@standrews-de.org

Anaphylaxis Emergency Action Plan

STUDENT NAME: _____ AGE: _____

ALLERGY TO: _____

ASTHMA: ☐ **YES (high risk for severe reaction)** ☐ **NO**

Other health problems besides anaphylaxis: _____

Current medications, if any: _____

Wear medical identication jewelry that identifies the anaphylaxis potential and the food allergen triggers.

SYMPTOMS OF ANAPHYLAXIS INCLUDE:

- MOUTH—itching, swelling of lips and/or tongue
- THROAT*—itching, tightness/closure, hoarseness
- SKIN—itching, hives, redness, swelling
- GUT—vomiting, diarrhea, cramps
- LUNG*—shortness of breath, cough, wheeze
- HEART*—weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
* Some symptoms can be life-threatening! **ACT FAST!**

WHAT TO DO:

1. **INJECT EPINEPHRINE IN THIGH USING (check one):**
   - ☐ **Adrenaclick (0.15 mg)**
   - ☐ **Adrenaclick (0.30 mg)**
   - ☐ **EpiPen Jr (0.15 mg)**
   - ☐ **EpiPen (0.30 mg)**

   * *Note: Patients should be allowed to self-carry and self-administer epinephrine; medications shown in alpha order; make sure a doctor has provided a prescription for th eright medication for this patient, that it is current/not expired; and always keep this medication within reach of the patient.*

   Other medication/dose/route: _____

IMPORTANT: Asthma inhalers and/or antihistamines can't be depended on in anaphylaxis!

2. **CALL 9-1-1 or RESCUE SQUAD (before calling contacts)!**
3. **EMERGENCY CONTACTS**

   #1 home _____ **work** _____ **cell** _____
   #2 home _____ **work** _____ **cell** _____
   #3 home _____ **work** _____ **cell** _____

DO NOT HESITATE TO GIVE EPINEPHRINE!

COMMENTS:

_____

➡ **X** _____
DOCTOR'S SIGNATURE/DATE

➡ **X** _____
PARENT'S SIGNATURE/DATE

➡ **X** _____
STUDENT'S SIGNATURE/DATE

† Adapted from J Allergy Clin Immunol 1998; 102:173-176 and J Allergy Clin Immunol 2006; 117:367-377.

St. Andrew's School
350 Noxontown Road
Middletown, DE 19709-1605

Health Center

Checklist for Health Forms for NEW Students

Please use this checklist before submitting your health forms to the Health Center.

All Health Forms MUST be received by: June 30, 2019

✓ Required Forms for NEW Students (unless otherwise noted):

STEP 1

- ☐ 1. Health Center Google Questionnaire

STEP 2

- ☐ 2. Student Information and Medical Authorization – Page HCF-1
- ☐ 3. Health & Accident Insurance Enrollment Form – Page HCF-2
- ☐ 4. Insurance and Care Provider Information – Page HCF-3
- ☐ 5. Confidential Medical History Record – Page HCF-4
- ☐ 6. Tuberculosis (TB) Risk Assessment Questionnaire – Page HCF-5
- ☐ 7. Delaware Interscholastic Athletic Assoc. Parent/Guardian/Student Consents – Page DIAA-1
- ☐ 8. DIAA Pre-Participation Physical Evaluation History Form – Page DIAA-2
- ☐ 9. DIAA Pre-Participation Physical Evaluation Physical Examination Form – Page DIAA-3
- ☐ 10. DIAA School Athlete Medical Card – Page DIAA-4
- ☐ 11. Asthma Action Plan (required only for students who have Asthma)
- ☐ 12. Seizure Action Plan (required only for students who have seizures)
- ☐ 13. Anaphylaxis Emergency Care Plan (required only for students who have severe allergies)

✓ Other Required Information for NEW Students:

- ☐ 13. Immunization Record
- ☐ 14. Insurance Card(s) - (Medical, Prescription, and Dental) Please include an ENLARGED copy of the FRONT and BACK of all insurance cards (medical, prescription, and dental).

✓ Required Signatures:

Parent / Guardian Signatures Required *(Total of 9, possibly *12)*

- ☐ Page HCF-1
- ☐ Page HCF-2
- ☐ Page HCF-3
- ☐ Page DIAA-1 (4 signatures)
- ☐ Page DIAA-2
- ☐ Page DIAA-4
- ☐ *Asthma Action Plan (required only for students who have Asthma)
- ☐ *Seizure Action Plan (required only for students who have seizures)
- ☐ *Anaphylaxis Emergency Care Plan (required only for students who have severe allergies)

Student/Athlete Signatures Required *(Total of 4, possibly *7)*

- ☐ Page HCF-3
- ☐ Page DIAA-1 (Question #1 only)
- ☐ Page DIAA-2
- ☐ Page DIAA-4
- ☐ *Asthma Action Plan (required only for students who have Asthma)
- ☐ *Seizure Action Plan (required only for students who have seizures)
- ☐ *Anaphylaxis Emergency Care Plan (required only for students who have severe allergies)

Physician/Healthcare Provider Signatures Required *(Total of 3, possibly *6)*

- ☐ Page HCF-4
- ☐ Page DIAA-3
- ☐ Page DIAA-4
- ☐ *Asthma Action Plan (required only for students who have Asthma)
- ☐ *Seizure Action Plan (required only for students who have seizures)
- ☐ *Anaphylaxis Emergency Care Plan (required only for students who have severe allergies)