ST. ANNE'S-BELFIELD SCHOOL
BOARDING PROGRAM HEALTH EXAMINATION FORM

Developed in consultation with Pediatric Associates of Charlottesville and Adolescent and Young Adult Health Center, 1011 East Jefferson Street, Charlottesville, VA (434) 971-9611 and The University of Virginia Teen and Young Adult Center, 1204 W. Main Street, Charlottesville, VA (434) 982-0090.

Physical examinations must be completed after May 1st and
submitted via email by July15th to the Director of Residential Life
Director of Residential Life: Antxon Iturbe; aiturbe@stab.org
All forms will be reviewed by a licensed health care provider

Given Name ____ American Name _________________
(last) (first) (middle)

Birth Date ___/___/___ Country of Birth________________ Sex________ Age ______ Grade ______
MO DD YY

Student's Primary Language: ____________________ Parent's Primary Language: ________________

Student resides with (please circle one): Both parents Mother Father Other___________________

Mother or Guardian________________________ Email _________________ Phone_______________

Father or Guardian_________________________ Email_________________ Phone________________

Emergency Contact________________________ Relationship____________ Phone________________

Health Insurance Information: Company ____

Group Number _________________________________ Policy Number________________________

Name & Date of Birth Policy Holder ____

Health insurance is required. Please attach copy of card. If you purchased school insurance, leave this section blank. Changes to insurance during the year should be emailed to Director of Boarding.

To the best of my knowledge, the medical history information on the following page is correct and the person herein described has permission to engage in all prescribed school activities, except as noted by the examining physician and me.

______________________________	______________________________	__________________
NAME OF PARENT	SIGNATURE OF PARENT	DATE
NAME OF STUDENT	SIGNATURE OF STUDENT	DATE
NAME OF INTERPRETER	SIGNATURE OF INTERPRETER	DATE

PART II – MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician.
Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

MEDICAL HISTORY OF STUDENT & FAMILY	Yes	No	MEDICAL HISTORY OF STUDENT & FAMILY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	32. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	33. Have you ever had herpes skin infection?	☐	☐
3. Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	☐	☐	34. Have you ever had a head injury or concussion?	☐	☐
4. Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	35. Date of last head injury or concussion: Date: ______________________________		
5. Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	☐	☐	36. Have you ever been hit in the head and been confused or lost your memory?	☐	☐
6. Have you ever passed out or nearly passed out during or after exercise?	☐	☐	37. Have you ever been knocked unconscious?	☐	☐
7. Have you ever passed out or nearly passed out at any other time?	☐	☐	38. Have you ever had a seizure?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	39. Do you have headaches with exercise?	☐	☐
9. Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	☐	☐	40. Have you ever had a numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
10. Does your heart race or skip beats during exercise?	☐	☐	41. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
11. Has a doctor ever told you that you have (check all that apply): ☐High Blood Pressure ☐A heart murmur ☐High cholesterol ☐A heart infection			42. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
			43. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
12. Has a doctor ever ordered a test for your heart?	☐	☐	44. Have you had any other blood disorders or anemia?	☐	☐
13. Has anyone in your family died suddenly for no apparent reason?	☐	☐	45. Have you had any problems with your eyes or vision?	☐	☐
14. Does anyone in your family have a heart problem?	☐	☐	46. Do you wear glasses or contact lenses?	☐	☐
15. Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death)	☐	☐	47. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
16. Does anyone in your family have Marfan syndrome?	☐	☐	48. Are you happy with your weight?	☐	☐
17. Have you ever spent the night in a hospital?	☐	☐	49. Are you trying to gain or lose weight?	☐	☐
18. Have you ever had surgery?	☐	☐	50. Do you limit or carefully control what you eat?	☐	☐
19. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐	51. Has anyone recommended you change your weight or eating habits?		
20. Have you had any broken or fractured bones or dislocated joints?	☐	☐	52. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
21. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐	53. What is the date of your last Tetanus immunization? Date: ________________________________		
			FEMALES ONLY 54. Have you ever had a menstrual period?	☐	☐
22. Have you ever had a stress fracture?	☐	☐	55. Age when you had your first menstrual period? _______		
23. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐	56. How many periods have you had in the last 12 months? ______________		
24. Do you regularly use a brace or assistive device?	☐	☐	57. Do you take a calcium supplement?	☐	☐
25. Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐	**Explain "Yes" answers here: When listing current medications, please include dose, reason for taking and how long you have been taking it.**		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐			
27. Is there anyone in your family who has asthma?	☐	☐			
28. Have you ever used an inhaler or taken asthma medicine?	☐	☐			
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐			
30. Have you had infectious mononucleosis (mono) within the last three months?	☐	☐			
31. Have you ever had mono or any illness lasting more than two weeks?	☐	☐			

Parent/Guardian Signature: ________________________________ Student's Signature: ________________________________

PART III – PHYSICAL EXAMINATION

STUDENT NAME: ____ SCHOOL: ___________________________

HEIGHT: _________ WEIGHT: ____________ SEX: _____________ AGE: ____________ DOB: __________________

*Tanner Stage or Maturation Index: (males only) ______________________

*Percent Body Fat: __________________________________

*Audiogram _______________________________________

*Vision: Corrected (L) ___________(R) ____________ (Both) _________
Uncorrected (L) _________(R) ____________ (Both) _________

BP: _________________________

Pulse: *(rest) ____________________
*(Exercise) ____________________
* (Recovery) __________________
*FEV or Peak Flow (rest) ___________
*(Exercise) ____________________
*(Recovery) ____________________

	N	ABNORMAL		N	ABNORMAL
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ❑ **CLEARED WITHOUT RESTRICTIONS**
- ❑ Cleared **AFTER** further evaluation or treatment for:____
  ____
- ❑ Cleared for **Limited participation** (check and explain "reason" for all that apply):
  - ❑ Not cleared for (specific sports)____
  - ❑ Cleared only for (specific sports) ____

  Reason(s): ____
- ❑ **NOT CLEARED FOR PARTICIPATION**: ____

  Reason(s): ____
- ❑ Other Recommendations: ____
  - ❑ Recommend close monitoring during early conditioning because of weight/fitness/other
  - ❑ Recommend restrictions or monitoring of weight loss or gain
  - ❑ Other ____

  Reason(s): ____

Physician Signature: ____ [+] M.D. Date of Examination** _______________________
[+](MD, DO, LNP, PA)

Date Signed: __________________________________

Examiner's Name and degree (print): ______________________________ Phone Number ___________________________________
Address: _______________________________________ City ________________________ State _________ Zip ________________

ST. ANNE'S-BELFIELD SCHOOL
BOARDING PROGRAM MEDICAL AUTHORIZATION FORM

GIVEN NAME ____ **AMERICAN NAME:** _________________
(Last) (First) (Middle)

DATE OF BIRTH: _____/_____/_____ **CURRENT GRADE:** ___________ **AGE:** ___________
MO DD YY

CURRENT MEDICATIONS: ______________________________ **ALLERGIES:** __________________________

MEDICAL AUTHORIZATION: I hereby authorize any hospital or physician to render necessary medical care to the student named above. This authorization does not include medical care beyond what is usual and customary for treatment on an outpatient basis, but does include x-rays, blood work, urinalysis and appropriate medications.

1. In an emergency, if I cannot be reached by St. Anne's-Belfield School staff or hospital staff or by a treating physician, I consent for St. Anne's-Belfield staff to act *in loco parentis* and to grant permission for emergency treatment, including surgery requiring the use of an anesthetic.
2. I authorize the St. Anne's-Belfield staff to exchange medical information with health-care providers as necessary to ensure provision of appropriate medical care to my child.
3. I authorize any hospital or physician rendering necessary medical care to my child to provide copies of medical records and to share clinical information with the St. Anne's-Belfield staff.
4. I authorize St. Anne's-Belfield staff and their health care providers to inform St. Anne's-Belfield faculty and staff members about my child's medical conditions or treatments that may bear on his participation and performance in St. Anne's-Belfield's educational and athletic programs.
5. I authorize St. Anne's-Belfield to arrange for my child to get the required physical examination and/or immunizations if they are not completed upon arrival. I understand my child may not be allowed to stay on campus in the dormitory if he/she arrives without the completed requirements.

________________________________ ________________________ ___________________
Signature of parent or guardian Relationship Date

PHYSICAL EDUCATION REQUIREMENT
I understand physical activity is a requirement at St. Anne's-Belfield, and I understand that participation may include early dismissal from class and travel to participate in interscholastic athletic events. I will not hold the school authorities responsible in case of accident or injury as a result of athletic participation.

____________________________ ________________________ __________________
Signature of parent or guardian Relationship Date

MEDICATION CONSENT
I give St. Anne's-Belfield Boarding Program consent to keep our child's prescription or non-prescription medication. All medication instructions must be in English and include the name of the student as well as the dosage. Any medication not in English will be disposed of. I understand that school personnel who oversee our child taking medication may be inexperienced and untrained in this service, and we state, without reservations, that we shall not hold him or her or St. Anne's-Belfield School, Inc., liable in any way for harm or injury that may be experienced by our child as a results of this service. I understand that our child may be taken to the doctor due to illness and prescribed medication. We have listed any and all medications to which our child has any type of allergic reaction. We understand that the Director of Boarding will contact us via email when our child has been prescribed medication.

____________________________ ________________________ __________________
Signature of parent or guardian Relationship Date

INFLUENZA VACCINE CONSENT
The United States Center for Disease Control recommends that all people in the United States get a yearly vaccination for influenza. Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May. Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact. Anyone can get flu. Flu strikes suddenly and can last several days. Students can miss a number of days of school when sick with the flu. Students living in dorms are in closer quarters which makes it easier to spread the infection. Symptoms vary by age, but can include, fever/chills, sore throat, muscle aches, fatigue, cough, headache and runny or stuffy nose.
I give consent for my child to be given the influenza vaccine for this school year (circle yes or no): **YES** **NO**

____________________________ ________________________ __________________
Signature of parent or guardian Relationship Date