

CHATHAM HALL



PERMISSION TO TREAT AND DISCUSS MEDICAL CARE

Parental Consent / Medical History / Permission to Treat / Physical Exam / Athletic Participation
(All students must have had a Physical within one year)

All items on this page to be filled out by parent/guardian (please type or print legibly)

Student's Name _____ Nickname _____ SS# _____

DOB _____ Allergies/Medical Concerns _____

Primary Care Giver _____ Relationship _____ E-mail _____

Phone: Home _____ Work _____ Cell _____

Address _____

Secondary Care Giver _____ Relationship _____ E-mail _____

Phone: Home _____ Work _____ Cell _____

Address _____

STUDENT'S INSURANCE INFORMATION

Please attach a copy of insurance and prescription cards - front and back so we may get prior approval and bill properly for any medication or appointments your daughter may need.

If no card is attached, the full amount will be billed home.

(If you have no insurance please check here___)

PERMISSION TO TREAT

I hereby give permission for the staff of Chatham Hall to examine and provide treatment and testing as deemed necessary for my daughter's health. I give permission for emergency medical treatment to be provided as needed and for Chatham Hall staff to sign for such care if unable to locate me by phone. I acknowledge that I am aware of HIPPA regulations and give permission for the release of medical information to Chatham Hall and any other medical facility as may pertain to my child's care. I understand that the cost of outside appointments and treatment will be my responsibility and in non emergency situations every effort will be made to contact me before appointments or referrals are made.

Signature of Parent/ Guardian _____ Date _____

PART II - MEDICAL HISTORY

This form should be completed by parent prior to time of the physical examination and should be taken with physical examination form for review by the physician during the examination.

YES /NO Have you ever had any of the following? Please explain any YES answers.

_____ heart murmur _____
_____ high blood pressure _____
_____ other heart problems _____
_____ broken bones _____
_____ weak joints -ankles, knees _____
_____ concussion _____
_____ operation _____
_____ seizures or epilepsy _____
_____ Have you ever fainted or passed out? _____
_____ Have you ever been knocked out? _____
_____ Have you ever been hospitalized? _____
_____ Have you ever had psychiatric treatment? _____
_____ List any prescription medication and why you are taking and any protocols. _____

_____ Any illness lasting more than a week such as Mono? _____

_____ Do you wear contact lenses, hearing aides or dental appliances? _____
_____ A family history of heart problems, cancer, or sudden death before the age of 50 _____
_____ Have you begun menses and when? _____ Is this normal for you family history? _____

UPDATED IMMUNIZATIONS

(PLEASE ATTATCH A COPY OF COMPLETE IMMUNIZATION RECORD)

Dates of last immunization: Tetanus _____ Meningitis (MANDATORY) _____
Hepatitis B Vaccine Series (if received) 1) _____ 2) _____ 3) _____
Updated MMR (if received) _____ Tuberculin test within the last year? _____

Parent signature _____

Physician signature _____ Date _____

Physician name _____

Office / Address _____

Telephone _____ Fax _____

Part III -Physical Exam and Athletic Participation
(To be completed and signed by physician)

Name _____ DOB _____ HT _____ WT _____

Vision: (R) _____ (L) _____ (B) _____ Corrected: (R) _____ (L) _____ (B) _____ Glasses or Contacts? _____

Eyes _____ Nose _____

Ears _____ Hearing _____

Teeth _____ Skin _____

Lymphatics _____ Lungs _____

Back _____ Shoulders _____

Spine&Neck _____ Arms&Hands _____

Hips&Knees _____ Feet&Ankles _____

Heart _____ Abdomen _____

Genitalia _____ Peripheral Pulses _____

Neurological Assessment _____

Labs if Indicated: Hg _____ Hct _____ Other _____

Baseline VS: Temp . _____ Pulse _____ Resp. _____ BP _____

Athletic Participation

I have reviewed the medical history and the data above and make the following recommendations for participation in athletics:

Full Participation _____ No Participation _____ Limited Participation _____

If not full participation please give detailed reason, recommendations and date to resume activity if able.

Physician Signature _____ Date _____