STUDENT HEALTH EXAMINATION POLICY

ALL incoming Ninth grade students and **ALL** new upper-class students <u>must</u> show proof of having had a physical examination by their health care provider within the previous twelve months upon entering high school.

New students who transfer to Erskine Academy after the first day of school will be given **two weeks** from their first day of attendance at the school to submit a copy of this examination. **Sport physicals will not be accepted in substitute.**

Prospective Ninth graders or new students will be given a <u>School Health</u>

<u>Examination form</u> at the time which they register for classes at Erskine Academy. This form is to be completed by the parents and the health care provider and returned to the school nurse.

(For All Ninth Grade and New Students)

Before the 1st day of school, this form MUST be returned to: Erskine Academy

309 Windsor Road South China, ME 04358

TO BE COMPLETED BY PARENTS BEFORE EXAMINATION - PLEASE PRINT

Student:		Birthdate:	Grade:	
Address:				
Parents/Guardians:		Phone Number:		
HEALTH HISTORY : Please check, give date had as well as how it has been treated.	s and descr	ribe any of the following	g which your child	l has
Major Illness:		Medications:		
gery: Injuries:				
Allergies:	Seizures/Convulsions:			
*** TO BE COMPLETED BY THE HEALTH CARE PROVIDER ***				
Date of Examination:	Height:	Weight:	BMI:	BP:
Skin:		Lungs:		
Scalp:		Heart:		
Eyes:		Abdomen:		
Ears:		Hernias:		
Nose:		Bones/Joints:		
Dental:		Back (Scoliosis, Kypi	hosis):	
Throat:		Nutrition:		
Neck:		Hygiene:		
IMMU	NIZATIO	N INFORMATION		
Date of Varicella (Chicken Pox) Vaccine: /	/	Date of last Tdap:	/ /	
Age when Varicella (Chicken Pox) contracted:				
Immunizations(s) given at this exam:				
Please note any other information that the school should be aware of:				
This student may participate: (Check all that apply)		Regular Physical Education Activity Limited or modified activity Interscholastic Sports		

(See back for Authorization of Medication)

Authorization to Administer Medication Which Must Be Taken During School Hours

Student:	Grade:		
Name of Medication:			
Prescribing Provider:	Telephone:		
Reason for Medication:			
Dosage:	Time(s) to be Administered:		
Possible side effects and safety procedures:			
Prescribing Provider's Signature or Prescription Label	Date		
I understand that the above medication may be administed include a medically unlicensed person who has complete	· · · · · · · · · · · · · · · · · · ·		
I understand that if the medication is still in school sever be disposed of.	n (7) days after the last student day, the medication will		
Permission to Contact Prescribing Health Care Prov	idor		
I give my permission for the school nurse to contact the information about the medication and the administration share information with the provider about the effects of	above prescribing health care provider to obtain schedule. I give my permission for the school nurse to		
Signature of Parent or Legal Guardian	Date		
Talanhana: (U)			