St. John the Evangelist Catholic School, LGV

13311 Long Green Pike
Hydes, MD 21082

Dear parents and guardians,

Saint John the Evangelist Catholic School follows the Maryland public school requirements for your child to enter school for the first time. The following health forms are required and are found on our school website: stjohnschoollgv.org → Parent Portal → Forms and Documents → Medical. They may be submitted by emailing them to the school nurse or by uploading them to PowerSchool.

- Maryland Schools Record of Physical Exam – this must be completed within nine months prior to entering the public school system, or within six months after entering the system. Part 1 must be completed and signed by a parent; part 2 must be completed and signed by your child's provider. New students as well as rising sixth graders need this form.
- Immunization Form (DHMH 896) – evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through twelfth grade. New students, Kindergarteners, and rising seventh graders need this form.
- Blood-Lead testing Certificate (DHMH 4620) – evidence of blood testing is required for all students who reside in a designated at-risk area when first entering PreK, Kindergarten, and first grade. Your child's practitioner may choose to submit this or another document demonstrating that lead testing was done.
- Medication Permission Form – if your child requires a prescription medication to be administered in school (or if you would like your child to be able to take any OTC medication) you must have the physician complete one medication administration form per child per medication. Please note that all medications must be supplied by parents and will not be distributed to other students. All unused medication will be returned to you at the end of the school year.
- Asthma Action Plan – if your child has asthma and requires an inhaler, this form must be completed and signed by the provider. Please remember to also provide the inhaler and the completed Medication Permission Form.
- Food Allergy Action Plan – if your child has a food allergy and requires an Epi-pen, this form must be completed and signed by the provider. Please remember to also provide the Epi-pen, Benadryl, and the completed Medication Permission Forms.

Exemptions from a physical examination and/or immunizations are permitted if they are contrary to a student's or family's religious beliefs, or if a practitioner certifies that there is a medical reason not to receive a vaccine. Exemptions from blood-lead testing are permitted if it is contrary to a family's religious beliefs and practices. All exemption requests are submitted to the AOB superintendent who gives final approval.

Kelly Williams, RN
410-592-9585 x104
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PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH
To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?
□No □Yes Name(s) of Medications: _____

Is your child on any special treatments? (nebulizer, epi-pen, etc.)
□
No □Yes Treatment _____

Does your child require any special procedures? (catheterization, etc.)
No Yes
Parent/Guardian Signature _____ Date:_____

PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   □No □Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   □No □Yes _____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
_____				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider **or** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. _____
   □No □Yes
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   □No □Yes _____

7. **Screenings**	**Results**	**Date Taken**
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has

☐ no evident problem that may affect learning or full school participation ☐ problems noted above

_____

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date