This form is due by the first day of school.

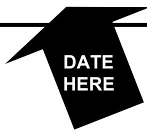
SAN MATEO UNION HIGH SCHOOL DISTRICT

MEDICAL EXAMINER'S STATEMENT ON HEALTH AND ACTIVITY STATUS

Student's Name ________________________________ Date of Birth ______________
Last First Middle

School ______________________________ Grade (Circle) 9 10 11 12

DATE OF EXAMINATION:



NOTE: Date of examination indicates beginning of 12-month eligibility for competitive athletics.

HT ________ WT ________ Blood Pressure ________

Visual acuity: without correction R________ L ________

with correction R________ L ________

Hearing loss: No_______ Yes _____

(If there is a hearing loss, please complete audiogram.)		500	1000	2000	3000	4000	6000
	R	___	___	___	___	___	___
	L	___	___	___	___	___	___

IMMUNIZATIONS (Give month and year)

Polio					
DTP/DTaP					
MMR				**Td**	**Tdap**
Hep B					
Hep A			**Varicella**		
HPV				**MCV**	

Date of last TB test ______________

Result of test ______________

History of BCG? ______________

Follow-up indicated______________

Date and result of chest x-ray______________

COMMENTS: ____

Please answer the following questions:

1. Is there a defect of vision, hearing, or speech for which the school should compensate by proper seating or other actions? [ ] Yes [ ] No
   If yes, please specify recommendations______________________
2. Are there previous operations, injuries, or illnesses of which the school should be aware?. . . . . [ ] Yes [ ] No
   If yes, please specify______________________
3. Is there a physical defect which limits participation in: Classroom activities? . . . . [ ] Yes [ ] No
   Physical Education? . . . . [ ] Yes [ ] No
   Competitive athletics. . . . . [ ] Yes [ ] No
   If yes, please specify limitation and recommendation for alternative activity ______________________
4. Is this student subject to a condition which may result in a classroom emergency (Epilepsy, fainting, diabetes, severe asthma, allergy, hypersensitivity to bee or other insect venom?). . . . . [ ] Yes [ ] No
   If yes, please specify ______________________
5. Is there an emotional mental or physical condition for which this student should remain under periodic medical observation?[ ] Yes [ ]No
   If yes, please specify ______________________
6. Is this student currently (or routinely) on medication? . . . . [ ] Yes [ ] No
   If yes, name of medication and dosage ______________________

7. Please complete the Authorization for Medication(s) During School Hours (on reverse side) for ANY medication the student may require during the school day.

Not Valid Unless Signed, Stamped & Dated

____

Signature of Physician or Health Care Provider

PLEASE STAMP/AFFIX NAME, ADDRESS, AND CONTACT INFORMATION OF PHYSICIAN/HEALTH CARE PROVIDER

Name:

Address:

Phone:

San Mateo Union High School District
Authorization for Medication(s) to be Taken During School Hours

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.
With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT: School Name____________________________

Student Name ____Gender______ Date of Birth_______________________
Last First

____(_______)________________
Physician/Health Care Provider's Name Address Telephone

In regards to the medication authorized below by her/his physician/health care provider:

I request that my student be assisted in taking the medicine(s) at school by authorized persons: Yes_____ No_____

I request that my student be permitted to carry medication & self-medicate her/himself: Yes_____ No_____

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

_____________ ____ (_______)_________________(______)_________________
Date **Signature of Parent/Guardian** **Home Phone** **Emergency**

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which medication is given:____

Name of medication:____

Form: ___________________Dose & route: ____

If medicine is to be given DAILY, at what time(s):____

If medicine is to be given WHEN NEEDED, describe indications: ____

How soon can it be repeated?: ___________________________ Length of time this treatment is recommended: ______________________________

List significant side effects of medication: ____

In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes_____ No_____

If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel: Yes_____ No_____ N/A_____

Date: ________________ **Signature of Authorized Health Care Provider:** ____

Health Care Provider Address Stamp (required):

Form #157 Medication Authorization Rev. 4/22 AH

Reviewed by Health Services ______________