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.

DATE HERE

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 **Name:**

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

Address:

Phone:

在學校期間服用藥物的授權
San Mateo Union High School District / Authorization for Medication(s) to be Taken During School Hours

根據加州教育法規 Section 49423 以及 Section 49423.6 的細項 (b)，任何學生在學校期間需要服用處方藥物，如果符合以下兩項條件，要由學校護士或其他指定代表協助。(a) 學生授權的醫護人員以書面聲明特別指示該學生服用的藥物、劑量、以及服用的時間，以及其它細節（如有必要），像服用的方法、數量、以及服用的時間表。(b) 學生的家長或法定監護人提供書面聲明要求給該學生服用藥物或由他人協助。這項書面聲明要與醫護人員的書面聲明吻合。

有學生醫護人員的授權以及學生家長或法定監護人的同意，當地的教育機關可以准許學生攜帶藥物並且自行服用。

以下部分要由家長填寫: 就讀學校_____

學生姓名 _____性別_____ 出生年月日_____

姓 名

_____(_____)_____

醫護人員姓名 地址 電話

針對以下學生醫護人員的藥物授權:

我要求我的子弟在校期間由授權人員協助服用藥物: **是_____ 否_____**

我要求准許我的子弟攜帶藥物並且自行服用: **是_____ 否_____**

我了解藥物一定要裝在藥房原本給的藥罐子裡，上面的標籤要有學生的姓名、開立處方的醫護人員姓名、以及藥物、最初開立的日期，該藥物的強度以及劑量、以及服用的方法。如果藥物放在學校的保健室，要在學年結束後一星期內或不需再服用該藥物後前來取回，否則該藥物會被銷毀。身為以上學生的家長/監護人，我因此對要求、行動、訴訟或任何責任、任何以及所有 San Mateo 聯合高中學區遵照我子弟醫護人員提供指示採取行動的人員提出求償。

_____ _____ **(_____)_____(_____)_____**

日期 家長/監護人簽名 住家電話 緊急連絡電話

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN/以下部分要由醫護人員填寫

Diagnosis for which medication is given/給予藥物的診斷:_____

Name of medication/藥物名稱: _____

Form/形式: _____ Dose and Route/劑量以及服用方式: _____

If medicine is to be given DAILY, at what time/如果每天都要服用，服用時間為:_____

If medication is to be given WHEN NEEDED, describe indications/如果藥物在需要的時候才給，描述需要的情況:_____

How soon can it be repeated?/藥物多快能再給?:_____

List significant side effects of medication/列出該藥物顯著的副作用: _____

Length of time this treatment is recommended/這個療程建議的時間: _____

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

以我的看法，該學生有能力攜帶並自行服用上述的藥物: /是(Yes)_____ /否(No)_____

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

如有需要，這個藥物可以被有受過訓練但沒有認可證書的學校員工安全地和正確地施用：是(Yes)_____ 否)(No)_____不適用 (N/A) _____

Signature of Authorized Health Care Provider:

Date/日期: _____授權醫護人員簽名: _____

Health Care Provider/授權醫護人員
Address Stamp Required/地址蓋章（必要）:

Reviewed by Student Health Coordinator _____