



Clinic Information and PE Clearance Form

Student's Name _____ Grade _____ DOB _____

The over-the-counter medications listed below may be given to my student on an as needed basis. All medications will be given at the weight appropriate doses recommended by the manufacturer. Please place an "X" over any medications you DO NOT want your child to have.

Hydrocortisone Cream Tylenol Ibuprofen TUMS Cough Drops

My child, as listed above, has my permission to participate in physical education and all other activities deemed appropriate and directed by Notre Dame Academy faculty/staff. I understand that all precautions will be taken to ensure the safety of the students. I also recognize that there are inherent risks involved in certain activities. Understanding that my child may need emergency medical treatment during school hours or at school activities while he/she attends NDA, I authorize the school, through its nurse or other qualified person, to administer such first aid or other medical treatment, including over the counter medications, as shall be deemed best under the circumstances. I consent for my child to receive such treatment. I understand that the school will attempt to notify parents in the event of an emergency requiring immediate medical care for my child. If school personnel are unable to notify parents, they will have my child treated by a duly qualified physician at the nearest appropriate emergency hospital or clinic. To ensure the care of my child, I agree that pertinent health information must be provided to and shared with appropriate school staff. I agree to alert the school nurse and my child's teacher of any change in medications and/or health status of my child. I will furnish the school with a current telephone number and address in case of an emergency.

I will personally deliver any prescription medications to the school nurse and complete the medication administration permission form.

Parent Signature

Parent/Guardian/Emergency Contacts:

Name: _____ Relation to child: _____ Contact # _____

Name: _____ Relation to child: _____ Contact # _____

Name: _____ Relation to child: _____ Contact # _____

Student's Physician: _____ Phone: _____

Student's Dentist: _____ Phone: _____

Please see other side

Name _____ Weight _____ D.O.B. _____ Grade _____

Parents, please answer the following questions about your child's health:

Has this child ever had any of the following? (Circle Y for yes, N for no)

Allergies: Bee, Wasp or Fire Ant	Y	N	Frequent headaches/migraines	Y	N	ADD/ADHD	Y	N
Allergies: Food	Y	N	Skin problems	Y	N	Frequent stomach aches	Y	N
Allergies: Medication	Y	N	Eczema	Y	N	Diabetes	Y	N
Asthma	Y	N	Irregular heartbeat or heart murmur	Y	N	History of Urinary Tract infections	Y	N
Inhaler: as needed or daily	Y	N	Fainting or dizziness w/exercise	Y	N	Anemia	Y	N
EpiPen / Auvi-Q	Y	N	Chest pain w/exercise	Y	N	Hemophilia	Y	N
Sinus Trouble	Y	N	Shortness of breath w/exercise	Y	N	History of Seizures	Y	N
Frequent Colds	Y	N	Frequent Nosebleeds	Y	N	High/Low Blood Pressure	Y	N
Chronic cough	Y	N	Family history of sudden death before age 50	Y	N	Another condition that might affect child	Y	N

If you answered YES to any of the items above, please provide an explanation and details below:

Medical Diagnosis: _____

Allergic to: _____ Reaction: _____

History of Anaphylactic Reaction: Y / N (circle one) If yes when: _____

Treatment for allergy: _____

If a child has a medical issue that may require medication contact the clinic to get the proper forms filled out. Any emergency medications necessary must be provided to the school by the parent(s). NDA needs to have Allergy, Asthma, Diabetic, Epileptic or any other Medical Action Plans on file in the clinic. The nurse can provide these forms for you to have filled out by their physician. Please contact the school nurse to formulate a plan for the treatment of your child's allergy, asthma, or any other medical issue that may require a plan or medication.

If Female, has your daughter started her period. Yes / No If yes, when? _____

Does the student take any medication? Yes / No. If yes, please indicate medication, reason for medication & dose: _____

Is medication taken daily or as necessary? _____

My child is physically fit to participate in regular physical education activities at Notre Dame Academy during the 2023-2024 school year. I certify that all answers are correct. I understand that any falsification will result in the child's suspension from the school activity for which he/she is a participant. This form is for school PE participation only.

A separate athletics physical evaluation must be obtained from a physician for extracurricular sports activities. The forms can be found on www.ndacademy.org. Athletics physicals are good for one calendar year.

Parent's signature _____ Date _____