



THE HOLTON-ARMS SCHOOL
7303 River Road • Bethesda, Maryland 20817

**THIS FORM IS DUE
JUNE 30
FOR ALL STUDENTS.**

STUDENT INFORMATION SHEET
(to be filled in by Parent/Guardian)

Student's Name (last name, first name) _____

Grade in Fall _____

Date of Birth _____

Country of Birth _____

Insurance Co. _____ Group # _____ ID # _____

MEDICAL PREFERENCES: Pediatrician: _____ phone _____
Dentist: _____ phone _____

In case of an emergency and/or WHEN NEITHER PARENT NOR GUARDIAN CAN BE REACHED by telephone, I give permission to the Head of School or, in his/her absence, to a designee to arrange transport to a hospital emergency room for EMERGENCY TREATMENT of illness or injury.

If my daughter chooses to take part in interscholastic athletics during this school year, I give my permission for her to participate and am aware of the potential risks. I agree to the administration by the School Nurse or her designate of any over-the-counter medication approved by the physician on page 3 of this form.

Signature of Parent or Guardian

Date

FOR EMERGENCY USE:

(Please include area codes for all phone numbers)

Home Phone: _____

Father/Guardian Name: _____

Workphone: _____

Carphone/Cell: _____

Mother/Guardian Name: _____

Workphone: _____

Carphone/Cell: _____

Name and phone number of relative or friend should parent be unavailable in an emergency [required]:

Name _____ Phone _____

Additional information about your child: _____

Restrictions due to religious beliefs: _____

MEDICAL HISTORY

Childhood Diseases: _____

Medical Illnesses: _____

Orthopedic Injuries: _____

Surgical Operations: _____

Allergies/Sensitivities: _____

Epi-Pen: Yes No

Asthma/Reactive Airway Disease: _____

Date of most recent Tetanus Booster: _____

*Your physician should fill out page 2 (if applicable), page 3 (required for all students), and page 4 (required of new students).
Record boosters on page 4 • Parents, please return this form to Holton-Arms School by June 30.*

NOTE: If additional information is needed, please attach additional signed information to this sheet.



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EMERGENCY HEALTH CARE PLANS (to be filled in by Physician)

Student: _____ Date: _____

FOR MANAGEMENT OF SEVERE ALLERGIC REACTIONS

Severe Allergy
to: _____

STAGE I:

With early signs including skin, GI, respiratory, or cardiac symptoms, including “thready” pulse, or passing out.
IF REACTION IS SUSPECTED, GIVE _____ by mouth immediately.
Call parents, guardian, or emergency contacts immediately.

STAGE II:

If symptoms develop in 2 or more systems or if throat, lung, or heart symptoms develop:
Give EPINEPHRINE INJECTION immediately!
Call RESCUE SQUAD immediately.
Call PARENTS/GUARDIAN IMMEDIATELY.

STUDENT ASTHMA PLAN

Identify likely causes of asthma onset: _____

Peak Flow Monitoring: _____ Personal Best Flow: _____

Daily Medication Plan: _____

STUDENT DIABETES PLAN

Insulin/Glucagon/Other Rx: _____

Signature of Physician: _____

Phone Number: _____

_____ [affix stamp here]



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**THIS FORM IS DUE
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PHYSICIAN'S EXAMINATION FORM

Physician's exam must be done within the same calendar year as the first day of school.

Student: _____ Grade (in Fall): _____

Height: _____ Weight: _____ Blood Pressure: _____

Date of Most Recent: TB Test* _____ Result: Neg. Pos.

* If student is foreign-born or has been out of the U.S.A. for 6 months, TB test is mandatory.

Date of Most Recent: Scoliosis screening _____ Result: Neg. Pos.

If either Pos., type of treatment _____

Past Medical/Surgical Hx: _____

SYSTEMS EXAMINED

Abdomen _____

EENT _____

Genitalia _____

Heart _____

Lungs _____

Neuro _____

Skeletal _____

ALLERGIES AND SPECIAL CONCERNS

Asthma _____

ADD _____

Drug Allergy _____

Food Allergy _____

Insect Allergy _____

Requires Epi-Pen _____

Diabetes _____

Seizure Disorder _____

Other _____

PRESCRIPTION DRUGS: _____

Medications dispensed at school (cross out any student should NOT receive):

| | | | |
|-------------------------------|---------------------------|--------------------------------|---|
| Ibuprofen/Acetaminophen | Maalox/Tums | Bacitracin | Calamine Lotion |
| *Benadryl/Diphenhydramine HCl | Robitussin-DM | Neosporin Cream | Cramp tabs (Midol) (Acetaminophen & Pamabrom) |
| Liquid Bandaid | Cough Lozenges | Visine Eye gtts | Medicine swabs |
| Diphenhydramine | Sudafed/Psedophedrine HCl | Hydrocortisone 0.5% & 1% Cream | Pepto Bismol chewable tablets |
| | | | Triaminic Thin Strips - Pediatric |

* If Benadryl is not allowed, please write alternative plan for REACTIONS on page 2.

These medications will be given by the Holton-Arms school nurse as directed by manufacturer instructions.

This individual is cleared for participation in athletics, contact sports, and physical education classes.

Medications not crossed out above are approved for this student.

Physician's Signature

Date of Exam*

*Physician's exam must be done within the same calendar year as the first day of school.

[affix stamp here]

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE ____/____/____
 COUNTY _____ SCHOOL _____ GRADE _____
 PARENT NAME _____ PHONE NO. _____
 OR GUARDIAN ADDRESS _____ CITY _____ ZIP _____

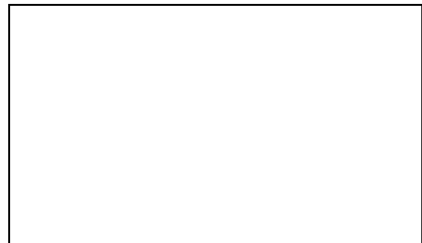
RECORD OF IMMUNIZATIONS (See Notes On Other Side)

| Vaccines Type | | | | | | | | | | | | | | |
|---------------|-------------------------------------|--------------------|------------------|--------------------|-------------------|------------------------|-------------------|------------------|--------|--------------------|------------------|------------------------|---|--|
| Dose # | DTP-DTaP DT-Td-Tdap Mo/Day/Yr | Polio Mo/Day/Yr | Hib Mo/Day/Yr | Heb B Mo/Day/Yr | PCV7 Mo/Day/Yr | Rotavirus Mo/Day/Yr | MCV4 Mo/Day/Yr | HPV Mo/Day/Yr | Dose # | Hep A Mo/Day/Yr | MMR Mo/Day/Yr | Varicella Mo/Day/Yr | History of Varicella Disease Mo/Yr | |
| 1 | | | | | | | | | 1 | | | | | |
| 2 | | | | | | | | | 2 | | | | | |
| 3 | | | | | | | | | | Other | Other | Other | Other | |
| 4 | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | |

To the best of my knowledge, the vaccines listed above were administered as indicated.

Office Stamp

- Signature _____ Title _____ Date _____
(Medical provider, local health department official, school official, or child care provider only)
- Signature _____ Title _____ Date _____
- Signature _____ Title _____ Date _____



Lines 2 and 3 are for certification of vaccines given after the initial signature.

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
 Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a permanent condition temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
 Physician or Health Officer

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____