CAP CANA HERITAGE SCHOOL

MEDICAL FORM

(2021-2022)

STUDENT'S NAME:	GRADE:
MY CHILD HAS HEALTH INSURANCE: YES ( ) NO ( )	COMPANY-POLICY NO.:
NAME OF DOCTOR:	PHONE:

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____

SYSTEM REVISION:	
GENERAL:	
HEAD:	
HEART RATE:	
TORAX:	
ABDOMEN:	
GENITOURINARY:	
EXTREMITIES:	
NEUROLOGICAL:	
OTHER:	

I certify that I have examined this child and find him/her physically able to compete in any supervised activities at school.

Y ( ) N ( )

If you indicated "No," please specify any restrictions the child might have:

_____
_____
_____

E. I certify that the above named child is completely immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, hepatitis A & B and rubella. Y ( ) N ( )

CCHS is not responsible for elevated risks associated with not vaccinating.

I certify that the information offered in this document is correct and up to date. I agree to give updates to the school on a regular basis on the conditions that my child might have or requested by Cap Cana Heritage School I understand that I am required to inform the school immediately if my child has a disease or there is a change in an existing condition. I acknowledge that Cap Cana Heritage School will do its best effort in caring for the well-being of my child.

NAME OF DOCTOR_____ Exequatur _____

Office phone: _____ Cel: _____

Work address: _____

Stamp: _____ Sign _____

PERSONAL PATHOLOGIC HISTORY

PROBLEMS WITH:	CHRONIC ILLNESS:
○ VISION [ ] ○ AUDITORY [ ] ○ EMOTIONAL DISORDER [ ] ○ FEBRILE CONVULSION [ ] ○ RECURRENT HEADACHE [ ] ○ MENSTRUAL CYCLE DISORDER [ ]	○ ASTHMA [ ] ○ DIABETES [ ] ○ EPILEPSY [ ] ○ HEART DISORDER [ ] ○ KIDNEY DISORDER [ ] ○ SURGERY HISTORY [ ]
STUDENT IS ALERGIC TO: MEDICINE, FOOD, OTHER? YES __ NO __ SPECIFY _____ _____ _____ STUDENT HAS TESTED POSITIVE FOR SARS-COVID-19? YES___NO___	DOES YOUR CHILD TAKE ANY MEDICATION? YES __ NO __ NAME OF MEDICINE: _____ WHY DOES HE/SHE TAKES THAT MEDICATION: _____ STUDENT IS CONSIDERED HIGH RISK FOR INFECTION WITH SARS-COVID-19? YES ___ NO_____

THE SCHOOL HAS PARENTAL CONSENT TO ADMINISTER THE FOLLOWING MEDICINE (S) TO YOUR CHILD:

MEDICATION	YES	NO
ACETAMINOPHEN		
ANTIALERGICS/ANTIHISTAMINES		
ANALGESICS		
ANTIESPASMODICS (SERTAL)		
ANTITUSIVE		
TOPICS (ANTIBACTERIAL, ANTIALERGIC, ANALGESIC CREAM)		

PEOPLE AUTHORIZED TO PICK UP STUDENT IN CASE OF EMERGENCY

COMPLETE NAME:	COMPLETE NAME:
PHONE/CEL:	PHONE/CEL:
ID NUMBER / PASSPORT:	ID NUMBER / PASSPORT:
RELATIONSHIP WITH STUDENT:	RELATIONSHIP WITH STUDENT:
COMPLETE NAME:	COMPLETE NAME:
PHONE/CEL:	PHONE/CEL:
ID NUMBER / PASSPORT:	ID NUMBER / PASSPORT:
RELATIONSHIP WITH STUDENT:	RELATIONSHIP WITH STUDENT:

I _____ authorize CCHS to give medical attention to my child at the closest clinic in case of an emergency.

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- Students that require medication at school must bring a written prescription from the doctor and must submit written parent consent to be administered at school. Contact the Nurse's Office at 809-695-5519 to obtain the form.
- The Nurse's Office may share some pertinent and important information with teachers and other school officials in particular cases for the well-being of the child.

Note: This Health form should be signed by both parents and/or guardians, if more than one.

Father/Guardian	Mother/Guardian
Name (Print): _____	Name (Print): _____
Signature: _____	Signature: _____
Date: _____	Date: _____