

# Harvard-Westlake School

## Health and Medical Information / Physician's Release

### School Year 2016-2017



This form is required for all students, and must be returned to the appropriate school office as soon as possible.

Student Name: Yuan, Siyi Grade: 7

Is your child planning to play sports at Harvard-Westlake School? Yes - soccer

**Note: Harvard-Westlake and CIF strongly recommend that student-athletes use the CIF pre-participation physical form to take to their physician and discuss any relevant medical issues. This is an additional form, for you and your doctor, and does not replace the HW Health and Medical Information/Physician Release form. The form can be found at: [https://www.hw.com/portals/3/enroll/12810281231\\_Pre-participation Physical Evaluation Form.pdf](https://www.hw.com/portals/3/enroll/12810281231_Pre-participation Physical Evaluation Form.pdf)**

#### I. HEALTH & MEDICAL HISTORY (as reported on the Health & Emergency Form during the enrollment process):

##### GENERAL:

Has your child had a medical illness or injury since his/her last physical? No

##### Does your child have any of the following on-going or chronic illnesses?

|                |    |
|----------------|----|
| a. Asthma      | No |
| b. Diabetes    | No |
| c. Anemia      | No |
| d. Sickle Cell | No |
| e. Other       | No |

Has a doctor told your child (or someone in your family) that he/she has sickle cell trait or disease? No

##### Does your child have any of the following allergies?

|                               |    |
|-------------------------------|----|
| a. Medications                | No |
| b. Foods                      | No |
| c. Stings/Bites               | No |
| d. Pollens/Seasonal Allergies | No |
| e. Other                      | No |

Has your child taken any supplements or vitamins to help lose weight, gain weight, grow? No

##### Is your child missing any of the following:

|                           |    |
|---------------------------|----|
| a. Kidney                 | No |
| b. Eye                    | No |
| c. Testicle (undescended) | No |
| e. Other                  | No |

Does your child cough or wheeze during or after physical activity? No

Has your child rapidly gained or lost a significant amount of weight over a short period of time? No

Does your child limit or carefully control what he/she eats or have a special diet? No

Has your child had or currently have problems with his/her eyes or vision? Yes - He have myopia and the prescription is 1.5

Has your child ever been hospitalized overnight? Yes - Colin once had pneumonia when he was 8 which he was hospitalized.

Has your child ever had surgery? No

##### ORTHOPEDIC:

Has your child ever had a sprain, strain, or tear of any muscles or ligaments? No

Has your child ever had a broken bone, stress fractures, or dislocated any joint? No

Do any of your child's joints become painful and/or swollen joints or ever been told your child has juvenile arthritis or connective tissue disease? No

##### CARDIAC:

Has your child ever passed out, had a seizure, near drowning or had pain/pressure in his/her chest during or after exercise, had a racing heart, skipped heartbeats, been told he/she has a heart murmur, high cholesterol or high blood pressure? No

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Has your child ever had tests for his/her heart (ECG/EKG, Echocardiogram, Stress Test)? No

Has any family member or relative died of a heart problem before the age of 50 or suddenly die (including drowning, or SIDS) or have a heart problem, unexplained fainting, seizures, near drowning, a pacemaker or implanted defibrillator? No

**Does your child or anyone in your family have any of the following?**

- |   |    |
|---|----|
| a. Hypertrophic Cardiomyopathy                                      | No |
| b. Marfan Syndrome  | No |
| c. Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD) | No |
| d. Long QT Syndrome   | No |
| e. Short QT Syndrome  | No |
| f. Brugada Syndrome   | No |
| g. Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)     | No |
| h. Other Heart Condition  | No |

Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? No

Has anyone in your family had unexplained fainting, seizures, or near drowning? No

Has your child had a severe viral infection (myocarditis, mononucleosis)? No

**NEUROLOGICAL:**

**Has your child ever had:**

- |   |    |
|---|----|
| a. Head injury                                      | No |
| b. Concussion                                       | No |
| c. Frequent, severe headache, or prolonged headache | No |
| d. Migraine   | No |
| e. Memory loss                                      | No |
| f. Seizure  | No |

**MEDICATIONS:**

Over-the-counter/prescription medication required by student on a regular basis No

**MISCELLANEOUS:**

Does your child have any developmental/emotional problems (ADHD, anxiety, depression)? No

Does your child have any concerns you would like to discuss with someone (psychological, social, academic or family issues)? No

Please tell us of any other medical issues that have not been mentioned: Colin once had pneumonia when he was 8 which he was hospitalized.

Prior Physician's abnormal medical findings mentioned in the past: N/A

**Signatures affirm that all pertinent health forms have been read and reviewed and that information is complete, accurate, and up-to-date.**

Doctor's Signature: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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#### II. PHYSICIAN'S EXAM AND RELEASE TO PARTICIPATE:

**Student/Parent must discuss with the physician family history; please note and circle if in your family you have knowledge or history of:** Marfan Syndrome, heart problems/arrhythmia, death at a young age, sudden death, seizures, sickle cell anemia, diabetes, unexplained dizziness, difficulty breathing, high cholesterol, eating disorders, general orthopedic problems, any major medical condition however vague or trivial, please report and discuss it with your physician for possible further assessment or evaluation.

|                             |                                  |                       |                 |
|-----------------------------|----------------------------------|-----------------------|-----------------|
| Height: _____               | Weight (lbs): _____              | Pulse: _____          | BP: ____ / ____ |
| Vision: R 20/____ L 20/____ | Corrected Glasses/lenses: YES NO | Pupils: Equal Unequal |                 |

**Please list any abnormal findings as the result of physical exam. Include treatment and follow-up treatment needed.**

|                        | Normal | Abnormal Findings | Initial |
|------------------------|--------|-------------------|---------|
| <b>Medical</b>         |        |                   |         |
| Appearance             |        |                   |         |
| Eyes/Ears/Nose/Throat  |        |                   |         |
| Lymph Nodes            |        |                   |         |
| Heart                  |        |                   |         |
| Pulses                 |        |                   |         |
| Lungs                  |        |                   |         |
| Abdomen                |        |                   |         |
| Genitalia (Males)      |        |                   |         |
| Skin                   |        |                   |         |
| <b>Musculoskeletal</b> |        |                   |         |
| Neck                   |        |                   |         |
| Back                   |        |                   |         |
| Shoulder/Arm           |        |                   |         |
| Elbow/Forearm          |        |                   |         |
| Wrist/Hand             |        |                   |         |
| Hip/Thigh              |        |                   |         |
| Knee                   |        |                   |         |
| Leg/Ankle              |        |                   |         |
| Foot                   |        |                   |         |

#### PHYSICIAN RELEASE

- ☐ Cleared for full participation, including athletics and physical education classes, based on the history and my physical examination.
- ☐ Cleared for school attendance only.
- ☐ Not cleared for: \_\_\_\_\_
- Recommendation(s): \_\_\_\_\_

**Signing below confirms that a review of the family history and a complete physical was done. If the exam is performed by a nurse practitioner or PA, it must be co-signed by an MD.**

Name of Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Exam is valid only if dated after April 1, 2016.