KAMEHAMEHA SCHOOLS®

MEDICAL FORMS: 2017 Explorations Series
Deadline: **February 15, 2017**

MEDICAL FORMS
The enrichment program that your child is applying to is a rigorous program requiring healthy learners. If medical conditions change at anytime, please contact us to update your child's medical form. Complete the attached forms:

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1. Kamehameha Schools: **Health History (HH) form; and**

2. Kamehameha Schools: **Physical Examination (PE) form**
Due: February 15, 2017

The **HH** and **PE** forms are required for the program your child is applying to:

1. First, complete your child's **HH** form.
2. Then, take the completed **HH** form along with the **PE** form to your child's doctor and have him/her complete the **PE** form.
3. Tell your child's doctor that the **date of the physical examination** must be on or after **JANUARY 1, 2016.** If your child has already had a physical examination after this date, your healthcare provider can complete the physical examination form based on that physical examination. Also, notify your child's doctor that your keiki will need a current **tetanus booster** (located at the bottom of the **PE** form, above the medical clearance box).
4. Tell your child's doctor to indicate if your child is medically cleared to participate in the Kamehameha Schools program in the **MEDICAL CLEARANCE** box at the bottom of the PE form and to indicate by writing "**NONE**" if there are no medical restrictions to participate.

NOTE: TUBERCULOSIS (TB) CLEARANCE REQUIRED FOR OUT-OF-STATE RESIDENTS ONLY:
New applicants who are out-of-state residents must submit documentation of TB screening using the Mantoux tuberculin test to include the date administered, date read, diameter of induration, and the signature of the person who read the result. This screening must be done on or after **January 1, 2016.**

3. Request for Administration of Medication (RAM) form
Due: February 15, 2017

Kamehameha Schools is not responsible for any medications that a student self-administers. Students will be responsible for ensuring that they keep their self-administered medication available at school or on any activity and take the medication as prescribed. If a student shares a self-administered medication with another student, the medication shared will immediately be confiscated, the student's privilege of self-administration will be revoked, and the student may face other disciplinary measures. However, students are not permitted to self-administer any controlled medications (e.g. narcotics or common ADHD medications); these medications will be administered by KS medical staff or their designee.

You will be required to complete a Request for Administration of Medication (RAM) form for each medication only:

- ***If you would like to have KS medical staff or their designee administer medication to your child; or***
- ***If your child has been prescribed a controlled medication that he or she may need to take during the program.***

If this applies to your keiki, be sure to take the **RAM** form to your child's physician along with the **PE** and **HH** forms to complete.

Send Completed forms to:
KS Admissions Office | 1887 Makuakāne Street • Honolulu HI 96817
or email to: admissions@ksbe.edu | Tel. 808.842.8800

Kamehameha Schools: **Health History (HH) form**

Due: February 15, 2017

Applicant's Legal Name: _____ _____ _____
Last First Middle

Gender: (check one) ❑ M ❑ F Birthdate: ____/____/_____ Grade Entering: _____ Program Applying To: _____
mm dd yy

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Health Questions About You	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High Blood Pressure ☐ A heart murmur ☐High cholesterol ☐ A heart infection ☐Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Heart Health Questions About Your Family	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Questions	**Yes**	**No**
17. Have you ever had any stress fracture, broken or fractured bones, or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)?		
20. Do you regularly use a brace, orthotics, or other assistive device?		
21. Have you ever had or do you currently have a bone, muscle, or joint injury that bothers you?		
22. Do any of your joints become painful, swollen, feel warm, or look red?		
23. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. In the past year, have you used an inhaler or taken asthma medicine?		
26. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
27. Do you have groin pain or a painful bulge or hernia in the groin area?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Have you had a herpes or MRSA skin infection?		
30. Have you ever had a head injury or concussion? If so, date of last occurrence:		
31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
32. Do you have a history of seizure disorder?		
33. Do you have headaches with exercise?		
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. Have you ever become ill while exercising in the heat?		
37. Do you get frequent muscle cramps when exercising?		
38. Do you or someone in your family have sickle cell trait or disease?		
39. Have you had any problems with your eyes or vision?		
40. Have you had any eye injuries?		
41. Do you wear glasses or contact lenses?		
42. Do you wear protective eyewear, such as goggles or a face shield?		
43. Do you worry about your weight?		
44. Are you trying to or has anyone recommended that you gain or lose weight?		
45. Are you on a special diet or do you avoid certain types of foods?		
46. Have you ever had an eating disorder?		
47. Do you have any concerns that you would like to discuss with a doctor?		
48. Do you take any nutritional or dietary supplements?		
Females Only	**Yes**	**No**
49. Have you ever had a menstrual period?		
50. How many periods have you had in the last 12 months?		

For "Yes" responses, provide details below (use additional sheets if needed):

_____
Signature of Parent/Guardian Date

Send to: **KS Admissions Office | 1887 Makuakāne Street • Honolulu HI 96817 or email to: admissions@ksbe.edu | Tel. 808.842.8800**

Kamehameha Schools: **Physical Examination (PE) form** | **Due: February 15, 2017**

Applicant's Legal Name: _____ (Last) _____ (First) _____ (Middle)

Gender: (check one) ❑ M ❑ F Birthdate: ____/____/_____ (mm dd yy) Grade Entering: _____ Program Applying To: _____

Residency: ☐ Hawai'i state ☐ Out-of-state // ☐ Returning ☐ New Student

PHYSICIAN TO COMPLETE (PLEASE COMPLETE ALL FIELDS)

Medical and Mental Health Conditions:	**Allergies** (please list reaction):
Current Medications: Epi-Pen ☐ Yes ☐ No	**Additional Comments:**

Height:	Weight:	BMI:	Vision: R 20 / L 20 / Corrected ☐ Yes ☐ No
BP:	Pulse:	**Normal**	**Abnormal Finding**

Appearance • Marfan stigmata		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
Musculoskeletal • Neck/back • UE/shoulder/elbow/wrist/hand • LE/hip/knee/ankle/foot • Functional/duck walk/single leg hop		
Mental Health • Depression • Tobacco Use		

→ **TB clearance required for OUT-OF-STATE residents only.**

• **Tuberculosis screening** (for out-of-state students only) Date Placed: Date Read: Result: mm

Date of last tetanus booster:

MEDICAL CLEARANCE

I have reviewed the completed Health History form, and I completed the physical examination for the above-named student. Based on my clinical assessment, the student ☐IS / ☐ IS NOT medically cleared to participate in the Kamehameha Schools program with the following restrictions (if none, please write NONE):

Name of Physician_____ **Examination Date*** ___/___/_____

Address_____ Phone (_____) _____–_____

Physician Signature_____ Today's Date ___/___/_____

→ ***NOTE:** Physical Examination date must be on or after **JANUARY 1, 2016.**

Send to: **KS Admissions Office | 1887 Makuakāne Street • Honolulu HI 96817 or email to: admissions@ksbe.edu | Tel. 808.842.8800**

Kamehameha Schools: **Request for Administration of Medicine (RAM)** | **Due: February 15, 2017**
(One medication per form)

Applicant's Legal Name: _____ _____ _____
Last First Middle

Gender: (check one) ❑ M ❑ F Birthdate: ____/____/_____ Grade Entering: _____ Program Applying To: _____
mm dd yy

Section I. Agreement and Release by Parent/Legal Guardian(s)

1. I/We, the undersigned, request and authorize Kamehameha Schools Health Services staff or their designee to administer medication, as prescribed by his/her health care provider, to my/our child named above.
2. I/We understand that this request pertains to prescription medications as well as regularly used prescribed over-the-counter medications.
3. I/We also understand that any changes in medication or dosage must be in writing and signed by the prescribing health care provider.
4. I/We hereby release and agree to indemnify, defend and hold forever harmless the Kamehameha Schools, its trustees, representatives, agents and employees from and against any and all claims arising from personal injury and/or property damage resulting from the administration of medication consistent with this request.

Kamehameha Schools is not responsible for any medications that a student self-administers. Students will be responsible for ensuring that they keep their self-administered medication available at school or on any activity and take the medication as prescribed. If a student shares a self-administered medication with another student, the medication shared will immediately be confiscated, the student's privilege of self-administration will be revoked, and the student may face other disciplinary measures. However, students are not permitted to self-administer any controlled medications (e.g. narcotics or common ADHD medications); these medications will be administered by KS medical staff or their designee.

_____ _____ _____
(Signature of Mother/Legal Guardian) (Printed Name of Mother/Legal Guardian) (Date)

_____ _____ _____
(Signature of Father/Legal Guardian) (Printed Name of Father/Legal Guardian) (Date)

Section II. Medication Information from Prescribing Healthcare Provider

Diagnosis: _____

Medication name/dose: _____

Directions for use: _____

Medication to be administered until: ____/____/____ OR ❑ End of Current School Year

Name of Physician_____ Phone_____

Address_____

Signature of Physician_____ Date_____

Office Use Only

The above request has been reviewed and the medication will be administered at school as requested.

_____ _____
(Clinical/ Medical Director) (Date)