ST. JOHN'S
COLLEGE HIGH SCHOOL | Est 1851

St. John's College High School requires all students to have a physical while attending the school. Non-athletes will have to submit physicals prior to their freshmen and junior years. Student-athletes must submit their physicals annually in order to participate in athletics and conditioning activities for St. John's.

The school recommends that all medical examinations should be performed by the child's pediatrician. However, other qualified medical professionals such as, a doctor of medicine (MD), doctor of osteopathy (DO), certified physician assistant (PA-C) or advance nurse practitioner may legally complete the medical examination. **Forms signed by any other practitioner will not be accepted and the parent/guardian will be notified to complete the physical again by one of the previously mentioned health care providers.** Current practitioner signatures on expired physicals will not be accepted and the student will need to have another physical performed by one of the aforementioned practitioners.

The medical forms can be found on the St. John's website or in your Magnus Health account and includes:

1. **DC Health Certificate** (2 pages) – Includes contents of the physical exam and immunization record. Must be signed and dated by the practitioner
2. **Dental Record –** to be completed by the dentist (only needed for freshman and junior years)
3. **HPV Opt-out form** – to be completed by the parent/guardian (can be done electronically on Magnus Health)
4. **Waiver of Liability and Parental Consent** – to be completed by the parent/guardian (can be done electronically on Magnus Health)
5. **Permission to Dispense Medication** – to be completed by the practitioner and parent or guardian.

St. John's utilizes electronic medical records to store the physicals and other health information on Magnus Health. The school nurse, athletic training staff, the counseling center and certain members of the administration are allowed access to view the information in order to care for a student. If a parent has questions regarding the use of this electronic platform or logging onto their account, the school nurse or athletic trainers can be contacted to rectify the issue.

After the medical examination, please upload the practitioner signed forms and complete the required on-line forms by August 1st. The school nurse and the athletic training staff will review the information and either accept or reject the information. The parent will receive notification via email (from Magnus Health) verifying the status of the account after the forms have been reviewed by either the school nurse or athletic training staff.

The procedure to complete and upload forms on a Magnus Health account is as follows:

1. Print the forms from our website or your Magnus Health account and have the forms signed by a practitioner at your appointment.
2. Scan/take a picture and save the documents on your device as a PDF file
3. Sign in to Magnus Health via our website or magnushealth.com
4. Upload the physician signed documents from your device (mailing or faxing the documents are also available but take longer to process. The directions are provided in the Magnus Health account)
5. Complete the required on-line forms and electronically sign where indicated
6. The procedures are completed and look for the email verification.

If you have any questions about how to complete the forms or what forms are needed, please contact the school nurse or athletic trainers.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer	
Race: *(check all that apply)*	❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ❑ Yes ❑ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature:_____ **Date:**_____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ___/___ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Developmental
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note._____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?

- ❑ High ➔ *complete skin test and/or Quantiferon test*
- ❑ Low

Skin Test Date:			**Quantiferon Test Date:**	
Skin Test Results:	❑ Negative	❑ Positive, CXR Negative	❑ Positive, CXR Positive	❑ Positive, Treated
Quantiferon Results:	❑ Negative	❑ Positive	❑ Positive, Treated	

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ❑ Normal ❑ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal ❑ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date:	**HGB/HCT Result:**

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by:_____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Coronavirus (COVID)	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:**_____

Medical Exemption (if applicable)

I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV
☐ COVID-19

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until:_____(date)

Reason for the medical exemption:_____

Alternative Proof of Immunity (if applicable)

I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or childcare activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from:_____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date:

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Human Papillomavirus (HPV) Annual Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM
Section 1: Enter student information
Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007) and the December 19, 2014 Notice of Rulemaking to expand Title 22 of the DC Municipal Regulations, the parent or legal guardian of a student enrolling in grades 6 through 12 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine this school year because:
    a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
    b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
    c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may readdress this issue at any time and complete the required vaccinations.

_____ _____
Signature of Parent/Guardian or Student if >18 years Date

_____
Print Name of Parent/Guardian or Student if >18 years

HUMAN PAPILLOMAVIRUS INFORMATION

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 12,000 women get cervical cancer and 4,000 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against four major types of HPV. These include two types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose: Now**
- **2nd Dose: two months after Dose 1**
- **3rd Dose: six months after Dose 1**

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-7130 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).

ST. JOHN'S
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Waiver of Liability and Parental Consent

This form is to notify the parent or legal guardian of the student attending St. John's College High School (SJCHS) of the associated risk with physical activities and to receive consent to treat and share the child's health information if an injury or illness occurs during a school sponsored event on or off campus.

Assumption of Risk and Waiver of Liability

I understand that there is an inherent risk of personal injury or death when travelling to/from school sponsored activities and participating in athletics, clubs and physical education classes. I accept these risks and allow my child to participate in such physical activities and waive any liability claim by me, my spouse and my child against the faculty and staff of SJCHS if an injury occurs.

Parental Consent to Treat

I, _____, as parent or legal guardian of, _____, graduation year _____, do authorize the school nurse, athletic training staff, associated physical therapist, associated team physicians, performance training, and other faculty/staff designated by the aforementioned people, and give them permission to administer, within their respective scopes of practices, any medical treatment deemed necessary for my child if an injury or illness occurs on or off the SJCHS campus when I'm not available to do so. I understand that medical treatment may include, but is not limited to, first aid, the distribution of medicine, both over the counter or the prescriptions that I provide to the school nurse, emergency care equipment, summoning Emergency Medical Services for advanced medical care, physician evaluation on campus, treatment modalities and physical rehabilitation in the athletic training room.

In cases of severe injury, I understand that every attempt will be made to contact me immediately by the faculty or staff when the injury occurs. If I am unable to be reached right away, I do not wish for care to be delayed so I give permission for the persons attending to my child to care first and then make the attempts to contact me again.

Parental Consent to Share Health Information

In order to care for a student with a physical injury or a mental concern, certain St. John's staff members may need to communicate pertinent medical or health information with one another. These designated individuals are directly responsible for caring for the student if an injury or illness occurs on or off campus. These individuals will include, but are not limited to, the school nurse, counseling center, athletic training staff, associated physical therapists, associated team physicians, attending Emergency Medical Services, coaching staff, performance training and certain members of the administration. In cases of mental health issues, shared information will be restricted to the counseling center, school nurse, athletic trainers (if a student-athlete) and certain members of the administration (if needed) on a need-to-know only basis. We understand a student's health information is to be kept private and any personal or medical information will not be shared with the student population or the public without the consent of the parent or guardian. The sharing of medical or health information amongst these individuals will only be used in cases of emergency, planning of care or prevention, and for medical releases back to school or sport.

I do understand that healthcare may come from many people in the St. John's community and so I grant permission that my child's medical or health information (all or partial) be shared amongst the pertinent staff members on a need-to-know only basis and as a means to properly care for my child with a physical injury or mental concern.

_____ _____

Parent/Guardian Signature Date

_____

Name of Parent/Guardian (Print)

ST. JOHN'S
COLLEGE HIGH SCHOOL | Est 1851

Authorization for Over-the-Counter Medication Administration

Student Name: _____ **Grade**: _____

The Nurse and the Athletic Training staff use OTC medications, ointments, liquids, gels, and powders in order to treat student-athletes who suffer from skin wounds/irritations, orthopedic injury or illness. In accordance with the law of the District of Columbia, no medication can be administered by the School Nurse, Athletic Training staff, or other school delegate without written consent by a parent/guardian **AND** physician/NP/PA.

Please check off all medication that can be administered.

- ○ Tylenol/Acetaminophen 500mg
- ○ Advil/Ibuprofen/Motrin
- ○ Benadryl/Diphenhydramine HCL
- ○ Tums
- ○ Pepto Bismol
- ○ Kaopectate
- ○ Claritin/Loratadine
- ○ Zyrtec/Cetirizine HCL
- ○ Sudafed/Phenylephrine HCL
- ○ Diatame (diarrhea/upset stomach)
- ○ Medicated Eye Drops (ie: Opcon-A)
- ○ Medication Nasal Spray (ie: Flonase)
- ○ Lubriderm lotion
- ○ Neosporin/Triple Antibiotic Ointment
- ○ Hydrogen Peroxide
- ○ Hydrocortisone cream
- ○ New Skin Liquid bandaid
- ○ Skin Stitch (wound adhesive)
- ○ BioFreeze
- ○ Hibiclens
- ○ Betadine
- ○ Burns Spray/Gel
- ○ Sting Kill (insect bites)
- ○ Gold Bond Powder
- ○ Caladryl/Calamine lotion

REQUIRED SIGNATURES: I have reviewed the medical history of this student and authorize the Nurse, Athletic Training Staff, or other school delegate to administer the above medications.

- ❑ Check off this box if the student can self-administer the above medication without supervision.

Physician/NP/PA Signature: _____ Date: _____

Physician/NP/PA Printed Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____