# Fall Sports Physical
# 2019-2020 School Year

- Your fall sports physical packet MUST be dated AFTER June 1, 2019.
- A date after June 1, 2019 is the only date acceptable on the Certification Date line on Section 6. (two dates are not acceptable on Section 6).
- Please make sure that the doctor dates the physical form. If the doctor does not date the physical form, the form will be returned to you.
- Your fall sports physical packet is due NO LATER than **Wednesday, July 31st** to the Athletic Office in order to play a fall sport.

# PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the current spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

## SECTION 1: PERSONAL AND EMERGENCY INFORMATION

Athlete's Name _____

Date of Birth _____ Age _____ Sport _____ Male / Female (circle one) Grade During Season _____

Current Address, City, Zip _____

Parent/Guardian Names _____

Parent/Guardian Email Address _____

Mother's Home # _____ Father's Home # _____

Mother's Work # _____ Father's Work # _____

Mother's Cell # _____ Father's Cell # _____

**EMERGENCY CONTACT INFORMATION – Other than Parent/Guardian**

Name _____ Relationship _____

Home # _____ Work # _____ Cell # _____

**HEALTH INSURANCE INFORMATION - MUST COMPLETE ENTIRELY** (May also provide a copy of insurance card)

(Please Circle One) Copy of Card Attached See Information Below No Health Insurance

Insurance Company Name _____ Type (circle one) HMO PPO HSA Other _____

Policy/Group # _____ Identification # _____

Card Holders Name _____ Card Holders Date of Birth _____

**MEDICAL INFORMATION**

Athlete's Health Condition(s) of which an Emergency Physician or other Medical Personnel Should be Aware _____

_____

Athlete's Prescription Medications and conditions of which they are being prescribed _____

Athlete's Allergies _____ Preferred Hospital _____

**ASTHMA AND EPI-PENS**

Does the athlete have ASTHMA? Yes or No (circle one) If yes, does the athlete carry an inhaler? Yes or No (circle one)
**If you answer yes to carrying an inhaler, your doctor MUST complete the authorization form attached to this packet or the student-athlete may not participate.**

Does the athlete carry an Epi-Pen? Yes or no (circle one) If yes, for what allergy _____
**If you answer yes to carrying an epi-pen, your doctor MUST complete the authorization form attached to this packet or the student-athlete may not participate.**

_____ _____

**Signature of Parent/Guardian** **Date**

## SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

**The student's parent/guardian must complete all parts of this form.**

**A.** I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

| Fall Sports | Signature of Parent or Guardian |
|---|---|
| Cross Country | |
| Field Hockey | |
| Football | |
| Golf | |
| Soccer | |
| Girls' Tennis | |
| Girls' Volleyball | |
| Water Polo | |
| Other | |

| Winter Sports | Signature of Parent or Guardian |
|---|---|
| Basketball | |
| Bowling | |
| Competitive Spirit Squad | |
| Girls' Gymnastics | |
| Rifle | |
| Swimming and Diving | |
| Track & Field (Indoor) | |
| Wrestling | |
| Other | |

| Spring Sports | Signature of Parent or Guardian |
|---|---|
| Baseball | |
| Boys' Lacrosse | |
| Girls' Lacrosse | |
| Softball | |
| Boys' Tennis | |
| Track & Field (Outdoor) | |
| Boys' Volleyball | |
| Other | |

**B. Understanding of eligibility rules:** I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date____/____/_____

**C. Disclosure of records needed to determine eligibility:** To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____ Date____/____/_____

**D. Permission to use name, likeness, and athletic information:** I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____ Date____/____/_____

**E. Permission to administer emergency medical care:** I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature _____ Date____/____/_____

**F. CONFIDENTIALITY:** The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature _____ Date____/____/_____

## SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

**What is a concussion?**

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

**What are the symptoms of a concussion?**

Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

**What should students do if they believe that they or someone else may have a concussion?**

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

**How can students prevent a concussion?** Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  - The right equipment for the sport, position, or activity;
  - Worn correctly and the correct size and fit; and
  - Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

**If a student believes they may have a concussion:** Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____Date____/____/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature _____Date____/____/_____

## SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

**What is sudden cardiac arrest?**

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

**How common is sudden cardiac arrest in the United States?**

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

**Are there warning signs?**

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

**What are the risks of practicing or playing after experiencing these symptoms?**

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

**Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)**

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

*Information about SCA symptoms and warning signs.*

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

*Removal from play/return to play*

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

| _____ | _____ | ____/____/_____ |
|---|---|---|
| Signature of Student-Athlete | Print Student-Athlete's Name | Date |
| _____ | _____ | ____/____/_____ |
| Signature of Parent/Guardian | Print Parent/Guardian's Name | Date |

Student's Name _____ Age_____ Grade_____

## Section 5: HEALTH HISTORY – MUST BE COMPLETED IN INK

***YES NO (please circle one) PLEASE EXPLAIN (AGE / DATE) ALL YES ANSWERS IN SPACE PROVIDED***

1) Y N Has a doctor ever denied or restricted your participation in sport(s) for any reason? _____

2) Y N Do you have an ongoing medical condition (like asthma or diabetes)? _____

3) Y N Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills? _____

4) Y N Do you have allergies to medicines, pollens, foods or stinging insects? _____

5) Y N Have you ever passed out or nearly passed out DURING exercise? _____

6) Y N Have you ever passed out or nearly passed out AFTER exercise? _____

7) Y N Have you ever had discomfort, pain, or pressure in your chest during exercise? _____

8) Y N Does your heart race or skip beats during exercise? _____

9) Y N Has a doctor ever told you that you have (circle all that apply and explain below):

High blood pressure Heart murmur High cholesterol Heart infection

10) Y N Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) _____

11) Y N Has anyone in your family died for no apparent reason? _____

12) Y N Does anyone in your family have a heart problem? _____

13) Y N Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?

_____

14) Y N Does anyone in your family have Marfan syndrome? _____

15) Y N Have you ever spent the night in a hospital? _____

16) Y N Have you ever had surgery? _____

17) Y N Have you had an injury, like a sprain, muscle or ligament tear or tendinitis, which caused you to miss a practice or contest? If yes, circle affected area below:

18) Y N Have you had any broken or fractured bones or dislocated joints? If yes, circle below?

19) Y N Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below

*Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest*

*Upper Back Lower back Hip Thigh Knee Calf/Shin Ankle Foot/Toes*

20) Y N Have you ever had a stress fracture _____

21) Y N Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? _____

22) Y N Do you regularly use a brace or assistive device? _____

23) Y N Has a doctor ever told you that you have asthma or allergies? _____

24) Y N Do you cough, wheeze or have difficulty breathing DURING or AFTER exercise? _____

25) Y N Is there anyone in your family who has asthma? _____

26) Y N Have you ever used an inhaler or taken asthma medicine? _____

## Section 5: HEALTH HISTORY – MUST BE COMPLETED IN INK – Cont'd

27) Y N Were you born without or are you missing a kidney, an eye, a testicle or any other organ? _____

28) Y N Have you had infectious mononucleosis (mono) within the last month? _____

29) Y N Do you have any rashes, pressure sore or other skin problems? _____

30) Y N Have you ever had a herpes skin infection? _____

**CONCUSSION OR TRAUMATICE BRAIN INJURY**

31) Y N Have you ever had a concussion (ie. Bell rung, ding, head rush) or traumatic brain injury? _____

32) Y N Have you been hit in the head and been confused or lost your memory? _____

33) Y N Do you experience dizziness and/or headaches with exercise? _____

34) Y N Have you ever had a seizure? _____

35) Y N Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? _____

36) Y N Have you ever been unable to move your arms or legs after being hit or falling? _____

37) Y N When exercising in the heat, do you have severe muscle cramps or become ill? _____

38) Y N Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? _____

39) Y N Have you ever had problems with your eyes or vision? _____

40) Y N Do you wear glasses or contact lenses? _____

41) Y N Do you wear protective eyewear, such as goggles or a face shield? _____

42) Y N Are you unhappy with your weight? _____

43) Y N Are you trying to lose or gain weight? _____

44) Y N Has anyone recommended you change your weight or eating habits? _____

45) Y N Do you limit or carefully control what you eat? _____

46) Y N Do you have any concerns that you would like to discuss with a doctor? _____

**FEMALES ONLY**

47) Y N Have you ever had a menstrual period?

48) _____ How old were you when you had your first menstrual period?

49) _____ How many periods have you had in the last 12 months?

50) Y N Are you pregnant?

**I hereby certify that to the best of my knowledge all of the information herein is true and complete.**

Student's Signature _____ Date____/____/_____

**I hereby certify that to the best of my knowledge all of the information herein is true and complete.**

Parent/Guardian Signature _____ Date____/____/____

## SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended. **Age 10-12:** BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Appearance | | |
| Eyes/Ears/Nose/Throat | | |
| Hearing | | |
| Lymph Nodes | | |
| Cardiovascular | | ☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation<br>☐ Physical stigmata of Marfan syndrome |
| Cardiopulmonary | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) | | |
| Neurological | | |
| Skin | | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | | |
| Back | | |
| Shoulder/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hand/Fingers | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot/Toes | | |

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone (  )_____

**AME's Signature**_____MD, DO, PAC, CRNP, or SNP *(circle one)* **Certification Date of CIPPE** ___/___/__

Berks Catholic High School

**Authorization for Inhaler and Asthma Action Plan**

(Form must be completed in its entirety)

Child's Full Name: _____ Grade _____ Date of Birth: _____

Drug Allergies: _____

All Current Medication: _____

**ACTION PLAN for Asthma Emergency – (Completed by physician)**

Triggers: _____

Symptoms: _____

Personal Best Peak Flow: _____

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**Request for Medication Use at School**

Name of Medication: _____

Dose to be given at school: _____ Time to be given at school: _____

Route of Administration: _____ Any instructions? _____

Date to start medication: _____ Date to end Medication: _____

Reason for medication: _____

Side Effects: _____

Does student understand side effects? _____ Any emergency response? _____

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**Parent Request for Medication Use at School**

According to the State Board of Nursing, no medication can be administered in school except by written request of a physician and with parent permission. According to Berks Catholic medication guidelines, a physician authorization is required for administration of prescription medication and over- the-counter medications. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Berks Catholic High School and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the medication.

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give my permission for the school and physician to communicate regarding this medication and medical condition.

_____ I believe my child is able and responsible to carry and self-administer his/her inhaler in school, during field trips, and extra-curricular activities (including athletics and music). I give my permission for him/her to do so. If my child uses his/her inhaler he/she will notify the nurse as soon as possible after using the medication.

_____ _____ _____

Date Printed Parent/Guardian Name Parent/Guardian Signature

Berks Catholic High School

**Anaphylaxis Medication Order & Emergency Action Plan**

Student Name: _____ Date of Birth: _____ Grade: _____

What is the life threatening allergen: _____

Does student have Asthma: _____ Yes (high risk for severe reaction) ____ No

Additional health problems besides anaphylaxis: _____

Concurrent Medications: _____

**Symptoms of Anaphylaxis:**

**MOUTH:** *itching, swelling of lips and /or tongue*
**SKIN:** *itching, hives, redness, swelling*
**LUNGS*:** *Shortness of breath, cough, wheeze*
**THROAT*:** *itching tightness/closure, hoarseness*
**GUT:** *vomiting, diarrhea, cramps*
**HEART*:** *weak pulse, dizziness, passing out*

*Only a few symptoms may be present. Severity of symptoms can change quickly!*
**Some symptoms can be lift-threatening.* ***ACT FAST!***

EMERGENCY ACTION STEPS- DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine into thigh using (check one):

☐ **Epinephrine Auto-injector (0.15mg)** ☐ **Epinephrine auto-injector (0.3 mg)**

**** IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN"T BE DEPENDED ON.****

2. Call 911 or rescue squad first then call emergency contact listed below:
3. Contact _____: home _____ work _____ Cell _____
   Contact _____: home _____ work _____ Cell _____
   Contact _____: home _____ work _____ Cell _____

**Parent/Guardian Authorization**

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give my permission for the school and physician to communicate regarding this medication and medical condition.

_____ I believe my child is able and responsible to carry and self-administer his/her inhaler in school, during field trips, and extra-curricular activities (including athletics and music). I give my permission for him/her to do so. If my child uses his/her inhaler he/she will notify the nurse as soon as possible after using the medication.

_____ _____ _____

Date Printed Parent/Guardian Name Parent/Guardian Signature

**(Student may carry Inhaler upon clearance by the nurse)**

(School Use Only _____Clearance to carry and self- administer an inhaler has been given and initialed by the school nurse.)

Adapted from the 2016 American Academy of Allergy, Asthma, & Immunology