

CONSENT FORM FOR MEDICAL CARE  
School Year 2011-2012



FREDERICK CAMPUS  
101 Clarke Place  
P.O. Box 250  
Frederick, MD 21705-0250

301.360.2000  
301.360.2001 TTY  
301.360.1400 FAX



COLUMBIA CAMPUS  
8169 Old Montgomery Road  
P.O. Box 894  
Columbia, MD 21044-0894

410.480.4500  
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410.480.4506 FAX



*Frederick Campus  
Established 1868*

*Columbia Campus  
Established 1973*



*The Maryland School for the Deaf does not discriminate on the basis of age; ancestry; color; creed; marital status; mental or physical disability; national origin; race; religious affiliation, belief, or opinion; sex or sexual orientation in matters affecting programs, activities, or employment practices.*

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_

1. As the parent/guardian of the student named above, I understand that **I am responsible** for immunization and physical examinations for my child, as well as for the management of any fees for my child's total health care. I understand that **I am responsible** for notifying the Maryland School for the Deaf of any aspects of my child's medical history of which the School should be aware of in the event of an emergency (e.g., allergy to penicillin, or contagious illnesses such as pink eye or ringworm, heart conditions, and chronic medical conditions).
2. I give my consent to transport for emergency medical, psychological, or surgical care, if necessary, to be administered to my child by MSD health care providers where appropriate, or by persons or facilities on or off campus, while he/she is enrolled at the School. I understand that I am responsible for all fees related to emergency medical or surgical care. **This authorization does not include the right to authorize any surgical procedures of a non-emergency nature.**
3. I give my permission for any medication prescribed to my child during the school year which I bring to the Student Health Center in the **original container from the pharmacy**, to be administered to my child by a School Nurse. I understand that unlabeled medications will not be given. **I understand that I must provide a Maryland State School Medication Administration Authorization Form signed by a physician or nurse practitioner and a parent/guardian for each prescribed medication to be given at School. I understand that if this form is not completed, the medication will not be given.**
4. I understand that I must keep a weekend and holiday supply of any routine medications at home. No medications will sent back and forth on weekends or holidays.
5. I give permission for my child to be administered over the counter medications by the School Nurse for treatment of minor medical issues as ordered by the Medical Director – Dr. Sajjad Aziz (e.g., Tylenol for headache, Robitussin for cough, and Chloraseptic for sore throat).
6. I give my consent for the Athletic Trainer at Maryland School for the Deaf to provide care and treatment to my child as indicated while he/she is enrolled in school-sponsored sports.
7. I give consent for Maryland School for the Deaf to give information to the physician or any health care provider contacted in accordance with this form regarding treatment received school.
8. I give consent for Maryland School for the Deaf to provide vision screening as required by the State of Maryland.
9. I give consent for the Student Health Center to exchange information with the Student's private physician, or any healthcare provider contacted regarding treatment received at the School.
10. I have read, understood, and consented to the conditions of the Maryland School for the Deaf medical policy. I understand that this policy shall apply to my child even as amended from time to time.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

**PARENT / LEGAL GUARDIAN PERMISSION FORM  
MSD ATHLETIC DEPARTMENT 2011-2012**

STUDENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

I hereby give my consent for the above-named student to represent his/her school in athletic activities, and to accompany any school team of which he/she is member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its choice, and emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree we/I will not hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel.

Check all that apply:

	YES	NO
<b>SUMMER CAMPS</b>		
Football Camp	<input type="checkbox"/>	<input type="checkbox"/>
Volleyball Camp	<input type="checkbox"/>	<input type="checkbox"/>
<b>FALL SPORTS</b>		
Cheerleading	<input type="checkbox"/>	<input type="checkbox"/>
Football	<input type="checkbox"/>	<input type="checkbox"/>
Girls Volleyball	<input type="checkbox"/>	<input type="checkbox"/>
<b>WINTER SPORTS</b>		
Boys Basketball	<input type="checkbox"/>	<input type="checkbox"/>
Cheerleading	<input type="checkbox"/>	<input type="checkbox"/>
Girls Basketball	<input type="checkbox"/>	<input type="checkbox"/>
Wrestling	<input type="checkbox"/>	<input type="checkbox"/>
<b>SPRING SPORTS</b>		
Baseball	<input type="checkbox"/>	<input type="checkbox"/>
Girls Softball	<input type="checkbox"/>	<input type="checkbox"/>
Track and Field	<input type="checkbox"/>	<input type="checkbox"/>
<b>SPRING CLINICS</b>		
Football	<input type="checkbox"/>	<input type="checkbox"/>
Girls Volleyball	<input type="checkbox"/>	<input type="checkbox"/>
Weight Lifting	<input type="checkbox"/>	<input type="checkbox"/>

Please check all sports that your child will or may participate during the year not just this fall. Please check weight lifting if your child participates in any sports.

STREET ADDRESS \_\_\_\_\_

CITY-STATE-ZIP CODE \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ VP or TTY or VOICE

WORK TELEPHONE \_\_\_\_\_ VP or TTY or VOICE

EMAIL ADDRESS \_\_\_\_\_

NAME OF PARENT / LEGAL GUARDIAN \_\_\_\_\_

PARENT'S / LEGAL GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**THIS FORM MUST BE COMPLETED IN ALL DETAILS AND FILED IN THE OFFICE OF THE ATHLETIC DIRECTOR BEFORE THE STUDENT WILL BE ALLOWED TO PRACTICE OR COMPETE IN ATHLETICS**

MARYLAND SCHOOL FOR THE DEAF

2011 - 2012

**STUDENT-ATHLETE CODE OF CONDUCT**

I, \_\_\_\_\_, as a member of any MSD athletic team, will follow and respect the following rules and standards of conduct (behavior). I understand that penalty for misconduct (not following these rules) can result in suspension or dismissal from the team as determined by the Student Handbook.

1. I will be **loyal** to my school and team. I agree to keep a **positive attitude** of encouragement toward my teammates all the time. I will give **100% effort** at all times during practices and games.
2. I understand if I quit or am dismissed from the team during the season, I will lose my privilege of joining any sport in the following season. The Athletic Director may approve an exception if the coach supports one, or if the circumstances merit it. There will be a two-week grace period for this to occur.
3. I will treat all people with **respect** all the time.
4. I understand I am a student **first** and am committed to getting the best education I can. I will do my best in the classroom.
5. I will inform my coach of any academic problems I may encounter. This includes low grades, term papers or upcoming tests, where I may need help or tutoring.
6. I will **safeguard my health**. I will not use any illegal or unhealthy substances, including alcohol, tobacco and drugs.
7. I will be **on time** to practices, meetings and games. I will follow my coach's dress and grooming code for both home and away games.
8. I understand I must personally get permission from my coach if I know I must be late to, or miss a team function. I will also inform my coach immediately if there is a transportation problem. I understand that being late to any team events for no reason will not be tolerated.
9. I will inform my coach immediately of any illness or injury that may affect my playing ability. I understand this may affect my playing time.
10. I will take good care of my practice and game uniforms. I understand I will have to pay to replace them if I am responsible for damaging them.

**I have read the above rules and standards. I agree to follow them.**

\_\_\_\_\_  
**Athlete Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

# MARYLAND SCHOOL FOR THE DEAF

## Emergency Medical Information Form

(Must be completed signed by parent/guardian)

Student's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Social Security # \_\_\_\_\_ - -  
 City State Zip Code

Parent/Guardian Name(s): Mother: \_\_\_\_\_ (H) ( ) - V - VP - TTY  
 (W) ( ) - V - VP - TTY  
 Pager # \_\_\_\_\_  
 Email \_\_\_\_\_

Father: \_\_\_\_\_ (H) ( ) - V - VP - TTY  
 (W) ( ) - V - VP - TTY  
 Pager # \_\_\_\_\_  
 Email \_\_\_\_\_

Additional Contact Person: Name: \_\_\_\_\_ (H) ( ) - V - VP - TTY  
 Relationship \_\_\_\_\_ (W) ( ) - V - VP - TTY  
 Pager # \_\_\_\_\_  
 Email \_\_\_\_\_

INSURANCE INFORMATION	Health Insurance Provider	Prescription Drug Plan	Other Insurance
Name of Company Address and Phone Number			
Policy Number			
Name of Policy Holder			

\*\*\*\*\*Attach Photo Copy of All Insurance Cards (front and back)\*\*\*\*\*

SCHOOL INSURANCE: Yes \_\_\_\_\_ No \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: ( ) - \_\_\_\_\_

Allergies: \_\_\_\_\_ Health Concerns: \_\_\_\_\_  
 \_\_\_\_\_ Restrictions: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

**(Note: Student must have a completed current physical exam form to participate in any sport)**

Any special requests: \_\_\_\_\_  
 \_\_\_\_\_

**Consent for Medical Care:**

In case of injury or sudden illness, I hereby authorize medical care to be provided by MSD Healthcare personnel. Further, I grant permission for any hospital or treatment facility to render immediate aid or emergency surgical care as might be required at the time for his/her health and safety. I understand that in order for medications to be administered, they must be in the original pharmacy bottle with label attached and dated within one year. I also understand that over-the-counter medications must be accompanied with a written order form a physician. I give my permission for MSD personnel to administer such medications. Attempts to notify parents/guardians regarding a medical emergency will always begin immediately.

\_\_\_\_\_  
 Parent/Guardian's Signature

\_\_\_\_\_  
 Date



**PART II – SCHOOL HEALTH ASSESSMENT**  
To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
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1. Does the child have a diagnosed medical condition?  
No Yes \_\_\_\_\_  
\_\_\_\_\_

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".  
No Yes \_\_\_\_\_  
\_\_\_\_\_

3. Are there any abnormal findings on evaluation for concern?  
Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)  
\_\_\_\_\_  
\_\_\_\_\_

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider **or** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicated medication and diagnosis.  
No Yes \_\_\_\_\_  
**(A medication administration form must be completed for medication administered in school).**

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.  
No Yes \_\_\_\_\_

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

**PART II – SCHOOL HEALTH ASSESSMENT – continued**

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) \_\_\_\_\_ has had a complete physical examination and has:  
\*\*\*\* no evident problem that may affect learning or full school participation \*\*\*\* Problems noted above

Additional Comments:

\*\*\*\* CLEARED FOR SPORTS OF ANY TYPE \*\*\*\*

- Cleared
- Cleared after completing evaluation/rehabilitation for:
- Not cleared for [Sport(s)]: Reason:

Recommendation:

Physician/Nurse Practitioner (type or print)	Phone No.	Physician/Nurse Practitioner	Date