Documenting History of Illness: Varicella (Chickenpox)

This form summarizes the **"Exceptions to Immunization Requirements (Verification of Immunity/History of Illness)"** incorporated in Title 25 Health Services §97.65 of the Texas Administrative Code (TAC)

§97.65 of the TAC states, "A written statement from a parent (or legal guardian or managing conservator), school nurse, or physician attesting to a child's positive history of varicella disease (chickenpox), or of varicella immunity, is acceptable in lieu of a vaccine record for that disease (see form at http://www.dshs.state.tx.us/immunize/docs/c-9.pdf)." School nurses may also write this statement to document cases of chickenpox that they observe. The school shall accurately record the existence of any statements attesting to previous varicella illness or the results of any serologic tests supplied as proof of immunity. The original should be returned to the child/student or the child's/student's parent or guardian. If a child or student is unable to submit such a statement or serologic evidence, varicella vaccine is required.

Documentation of prior varicella illness can be provided by the following methods:

1. A serologic confirmation of varicella immunity (positive varicella IgG result).

2. A written statement from a physician, school nurse, or the child's/student's parent or guardian containing wording such as:

"This is to verify _____had varicella disease (chickenpox)
(Name of student)

on or about _____and does not need the varicella vaccine."
(Approximate month/day/year)

TEXAS Department of State Health Services

_____
(Signature)

_____
(Relationship to student)

_____
(Date)

Visit our website at:
http://www.immunizetexas.com/

Mailing Address:
Texas Department of State Health Services
Immunization Branch
MC-1946
P.O. Box 149347
Austin, Texas 78714-9347

Documentando la Enfermedad de la Varicela (Chickenpox)

Esta forma resume las "Excepciones a los Requisitos de Inmunización (Verificación de la inmunidad/ historial de la enfermedad)" incorporadas en los Servicios Médicos §97.65 del Título 25 del Código Administrativo de Texas (TAC, por sus siglas en inglés).

§97.65 del TAC declara, "Una declaración por escrito de un padre (o guardián legal o manejador de bienes), enfermera de la escuela, o médico que atestigua a una historia positiva del niño de la enfermedad de varicela (viruela loca), o de la inmunidad de varicela, es aceptable en vez de un registro de vacuna para esa enfermedad (ver forma en http://www.dshs.state.tx.us/immunize/docs/c-9.pdf)." La enfermera de la escuela también puede escribir esta declaración para documentar cualquier caso de varicela que haya ocurrido en la escuela. La escuela debe anotar correctamente la existencia de cualquier documentación atestando a enfermedad previa de varicela o el resultado de prueba serológica dada como prueba de inmunidad. El documento original se debe devolver al niño o estudiante o al padre o tutor legal del niño o estudiante. Si el niño o estudiante no puede someter tal informe o evidencia serológica, la vacuna contra la varicela se requiere.

La enfermedad de la varicela debe ser documentada por medio de los siguientes medios de informe:

1. Prueba serológica que confirma inmunidad contra la varicela (resultado positivo de la prueba de la varicela IgG).

2. Un informe escrito por el médico, la enfermera de la escuela o el padre o tutor legal del niño que contiene palabras tales como las siguientes:

"Esto es para verificar _____tuvo la enfermedad de la varicela
(Nombre del estudiante)

en o por el día _____y no necesita la vacuna contra la varicela."
(mes/día/año aproximado)

TEXAS Department of State Health Services

_____
(Fecha)

_____
(Parentesco o relación al estudiante)

_____
(Firma)

Visite nuestro sitio Web en:
http://www.immunizetexas.com/

Dirección de correo:
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School Asthma Action Plan

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's Name:_____ Date of Birth:_____

Teacher's Name:_____ Grade:_____ School Year:_____

Parent/Guardian:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

(Star best number to contact first)

Asthma Specialist:_____ Phone:_____

Family Physician:_____ Phone:_____

Daily Treatment Plan

Please list any medication taken daily to manage asthma including nebulizer treatments

	Name of Medication	Purpose	Dosage	When to Use
1.				
2.				
3.				
4.				

These medications are prescribed for the time period_____ until_____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school (spacer, nebulizer, etc.)

_____

_____

_____

_____

_____

_____

(Over)

Emergency Treatment Plan

Emergency Action is necessary when this student has symptoms such as:

1._____ 2._____

3._____ 4._____

Steps to take during an asthma episode:

1. Give emergency medications: Bronchodilator (quick relief medication)

Name:_____

Purpose:_____

Dosage:_____ When to use:_____

Can be repeated for severe difficulty _____ times_____ minutes apart

Oxygen saturation with pulse oximeter (if available):Norms expected for student _____% to_____%

Call 911 or EMS if minimal or no improvement

Other medications:

Name: _____

Purpose:_____

Dosage:_____ When to use:_____

Additional instructions_____

These medications are prescribed for the time period_____ until_____

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Oxygen saturation is at or below _____%
- The student exhibits the following symptoms:

Chest and neck pulled with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips or fingernails turn gray or blue

Comments and special instructions:_____

_____

_____

Physician's Signature (stamp not accepted) Date

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions.

_____

Parent/Guardian's Signature Date

Allergy Action Plan

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's Name:_____ Date of Birth:_____

Teacher's Name:_____ Grade:_____ School Year: _____

Parent/Guardian:_____

Address:_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

(Star best number to call first)

Allergic to:_____

_____

Severe symptoms (One or more of the following):

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or combination of symptoms from different body areas:

Skin: Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut: Vomiting, crampy pain

PLAN

1. **Inject Epinephrine Immediately**
2. Call 911 - tell rescue squad epinephrine was given; request an ambulance with epinephrine
3. Note time when epinephrine was administered
4. Begin monitoring
5. Give additional medications:
   Antihistamine
   Inhaler (bronchodilator) if asthmatic

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction use Epinephrine

6. Stay with the student
7. Contact the parent/guardian

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.
For a severe reaction, consider keeping student lying on back with legs raised.
Treat student even if parents/guardians cannot be reached.

Medications/Doses

Epinephrine (brand and dose):_____

Antihistamine (brand and dose):_____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

(Over)

Allergy Action Plan

Mild symptoms:
Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

PLAN

1**. Give Antihistamine**
2. Stay with student: contact parent/guardian
3. Begin monitoring
4**. If** symptoms progress (see above), Use Epinephrine

Medications/Doses

Antihistamine (brand and dose):_____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

_____
Parent/Guardian Signature Date

_____
Physician/Healthcare Provider Signature Date

An allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician and a copy of this Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Parent/Guardian:_____ Phone: _____

Physician: _____Phone:_____

Other Emergency Contacts:

Name/relationship:_____ Phone: _____

Name /relationship: _____Phone:_____

_____
References: Allergyready.com
FAAN (www.foodallergy.org)

Preparticipation Physical Evaluation

HISTORY FORM

DATE OF EXAM _____

Name _____ **Sex** _____ **Age** _____ **Date of birth** _____

Grade ____ **School** _____ **Sport(s)** _____

Address _____ **Phone** _____

Personal physician _____

In case of emergency, contact

Name _____ **Relationship** _____ **Phone (H)** _____ **(W)** _____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
19. 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. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

47. 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 year? _____		

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ **Date of birth** _____

Height _____ **Weight** _____ **% Body fat (optional)** _____ **Pulse**_____ **BP**____/____ (____/___ , ____/____)

Vision R 20/ _____ **L 20/** _____ **Corrected: Y N** **Pupils: Equal** _____ **Unequal** _____

Follow-Up Questions on More Sensitive Issues	Yes	No
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	☐	☐
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?	☐	☐
6. During the past 30 days, have you had at least 1 drink of alcohol?	☐	☐
7. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc	☐	☐

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary†			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
†Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type)_____ **Date** _____

Address _____ **Phone**_____

Signature of physician_____**, MD or DO**

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____ **Sex**_____ **Age**_____ **Date of birth**_____

❑ **Cleared without restriction**

❑ **Cleared, with recommendations for further evaluation or treatment for:** _____

_____

_____

_____

❑ **Not cleared for** ❑ **All sports** ❑ **Certain sports:** _____ **Reason:** _____

Recommendations: _____

_____

EMERGENCY INFORMATION

Allergies_____

Other Information _____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

❑ **Up to date (see attached documentation)** ❑ **Not up to date** Specify _____

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone**_____

Signature of physician _____, **MD or DO**

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____ **Sex**_____ **Age**_____ **Date of birth**_____

❑ **Cleared without restriction**

❑ **Cleared, with recommendations for further evaluation or treatment for:** _____

_____

_____

_____

❑ **Not cleared for** ❑ **All sports** ❑ **Certain sports:** _____ **Reason:** _____

Recommendations: _____

_____

EMERGENCY INFORMATION

Allergies_____

Other Information _____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

❑ **Up to date (see attached documentation)** ❑ **Not up to date** Specify _____

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone**_____

Signature of physician _____, **MD or DO**

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