Form A2 Student Name: __________________________ Grade: _______ DOB: __________

Ivy Academy Chattanooga ♦ 8520 Dayton Pike ♦ Soddy Daisy, TN 37379
Phone: (423)305-7494 ♦ Fax: (423)305-7496

Physician Student Medical Form 2023-2024

Ivy Academy's curriculum has a heavy emphasis on education in the outdoors. Our students hike several times daily on a primitive trail system featuring varying terrains that include inclines, hills, rocks, etc. Students are expected to complete these hikes and keep up with their classmates and staff members. If students are unable to navigate these obstacles, we need documentation of needed accommodations. Ivy Academy will make accommodations for all students regardless of physical capability. ***All students are expected to hike daily unless a written statement from a physician is provided; parent notes will not be accepted.***

Student Name: __________________________________ Date of Birth: _______________________

I, ______________________________ (**physician name**), verify the above named student is capable of doing the following activities safely and healthfully. Please check applicable:

___ hike over rough terrain ___ navigate hills and inclines ___ walk over small to large rocks
___ walk at least 2 miles ___ be outdoors during warm weather ___ be outdoors during cold weather

Does the student have a history of any of the following conditions?
___ asthma (inhaler needed) ___ heart conditions ___ knee problems or surgeries
___ back problems or surgeries ___ recurring illnesses ___ severe allergies
___ allergies (requiring an EpiPen) ___ other medical condition(s)
___ muscular or skeletal conditions that would inhibit outdoor movement or student safety

Please explain any of the items checked above and the accommodations that may be needed for the condition:

____

____

Does the student have any other health conditions? Please list below and explain any restrictions/interventions that may be needed while the student is at school or on a school sponsored trip.

____

____

I, ______________________________ (**physician's name**), verify that ______________________________ (student's name) can safely participate in the outdoor learning environment at Ivy Academy with the above listed accommodations (if any).

Physician's Signature: ______________________________________ Date: _________________________

Note: The following pages are required if the student requires any prescription medications and/or any treatment plan, including inhalers and EpiPens. THIS INCLUDES ANY MEDICATIONS THAT COULD BE NEEDED DURING EXTENDED OR OVERNIGHT TRIPS SPONSORED BY THE SCHOOL.

Form A2 Student Name: __________________________ Grade: _______ DOB: __________

Individualized Student Medical Order

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ALLERGIES: ❑ ***Yes*** ❑ ***No***
List: ________________________________
History of Anaphylaxis? ❑ *Yes* ❑ *No*
EpiPen? ❑ *Yes* ❑ *No*
May student self-carry EpiPen? ❑ *Yes* ❑ *No*
Treatment/actions: ____________________________
____
____
**If epinephrine given, call 911 immediately. Notify parent/guardian.*

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SEIZURES: ❑ ***Yes*** ❑ ***No***
Does student have rescue medication? ❑ *Yes* ❑ *No*
Medication: _________________________________
Treatment/actions: ____________________________
____
____
**Call 911 if: 1st seizure, different or prolonged seizure pattern, repeated seizure, no breathing or pulse (start CPR), or if Diastat given and: a)Administered by non-medical staff; b)Nursing judgment indicates medical emergency based on situation and assessment; c)Parent or MD requests 911 call with seizure.*

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ASTHMA: ❑ ***Yes*** ❑ ***No***
Does student use a rescue inhaler? ❑ *Yes* ❑ *No*
May student self-carry inhaler? ❑ *Yes* ❑ *No*
Treatment/actions: ____________________________
____
____

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OTHER HEALTH CONDITION:
____
Treatment/actions: ____________________________
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Complete Medication List

Note: This includes any medications that may be needed during school-related activities and overnight field trips.

Name of Medication	Indication	Dosage	Route	Time	Side Effects	D/C Date

Notes:

Physician's Signature: ________________________________ Date: ______________________

Physician Name: ______________________________ Phone: ____________________________

Physician Address: _________________________ City: ____________________ Zip: __________

Parent Name: ______________________________ Parent Phone Number: ____________________

Parent Signature: ________________________________ Date: ___________________________

**Parent signature needed to implement above plans*