

La Pietra - Hawaii School for Girls

STUDENT'S HEALTH RECORD

Name _____
 (Last) (First) (Middle Initial)

Birthdate _____
 Month Day Year

Female ☐

Male ☐

Elementary: Entry Date ____/____/____

Intermediate/Middle: Entry Date ____/____/____ High:

Entry Date ____/____/____

Parent's Name _____
 (Mother/Guardian) (Father/Guardian)

Please complete the following sections **(CHECK IF YES)**

MEDICAL STATUS

Allergy (type) <input type="checkbox"/>	Cancer/Leukemia <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Rheumatic Heart <input type="checkbox"/>
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>
Vision Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Seizures <input type="checkbox"/>

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
					R.	L.	R.	L.																			
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)				Y	* N	IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)										Y	* N
Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)			DTaP, DTP, DT, or Td		Polio (IPV or OPV)		HIB <i>Haemophilus influenzae</i> type B		Hepatitis B	Varicella	MMR			
/ /	/ /			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given	DTaP <input type="checkbox"/> <input type="checkbox"/>		
/ /	/ /						/ /		/ /		/ /		/ /	/ /	/ /	Polio <input type="checkbox"/> <input type="checkbox"/>	
/ /	/ /					<input type="checkbox"/> <input type="checkbox"/>		/ /		/ /		/ /		/ /	/ /	HIB <input type="checkbox"/> <input type="checkbox"/>	
/ /	/ /					<input type="checkbox"/> <input type="checkbox"/>		/ /		/ /		/ /		/ /	/ /	HEP <input type="checkbox"/> <input type="checkbox"/>	
CHEST X-RAY							/ /		/ /		/ /		/ /	/ /	/ /	MMR <input type="checkbox"/> <input type="checkbox"/>	
Date	Results	Location					/ /		/ /		/ /		/ /	/ /	/ /	Varicella <input type="checkbox"/> <input type="checkbox"/>	
				<input type="checkbox"/> <input type="checkbox"/>		/ /		OTHER						Measles <input type="checkbox"/> <input type="checkbox"/>			
				<input type="checkbox"/> <input type="checkbox"/>		/ /	Type	Date Given		Date Given		Date Given		Mumps <input type="checkbox"/> <input type="checkbox"/>			
DENTAL EXAMINATION				<input type="checkbox"/> <input type="checkbox"/>		/ /		/ /		/ /		/ /		Rubella <input type="checkbox"/> <input type="checkbox"/>			
Dental Check-Up		/ /				/ /		/ /		/ /		/ /					

Student Athletic Physical Exam Form 2025-2026

Instructions to Parent: An annual physical exam is required each school year for all student-athlete. Please schedule an annual physical exam and ask your doctor to complete:

1. Student Health Form 14 and
2. 2025-2026 Student Athletic Physical Exam Form

Student Last Name

Student First Name

Grade

Athletic Participation List

The following sports are offered at La Pietra – Hawaii School for Girls:

Air Riflery	Cheerleading	Judo	Swimming	Water Polo
Archery	Cross Country	Flag Football	Tennis	Wrestling
Basketball	Diving	Soccer	Track & Field	Other:
Canoe Paddling	Golf	Softball	Volleyball	

Physician Certification

1. Date of exam:

2. This student:

- MAY participate fully in school PE and athletic activities as listed above.
- MAY NOT participate in school PE and athletic activities.
- Has RESTRICTIONS to participate in school PE and athletic activities. Please note restrictions:

Physician Name (print)

Physician Signature

Date



Student / Parent Acknowledgement

We, _____ and _____
(student-athlete name) (parent/guardian name)

acknowledge that we have read the 2025-2026 LP Practice Guidelines, LP Event Management Guidelines and the 2025-2026 Athletic Handbook for Students and Parents. We agree to follow all safety protocols and requirements stated for student-athletes and parents in these documents during the sports seasons.

We understand that failure to follow the parent and student-athlete guidelines in these documents will result in removal of the student from participation on the La Pietra or PAC-5 athletic team.

(student-athlete signature)

(date)

(parent/guardian signature)

(date)

Athletic Participation Agreement

I hereby request permission to compete in interscholastic athletics for La Pietra School. I have read the Athletic and School handbook pertaining to Sports and will adhere to those rules. I understand that an infraction of school/athletic rules will result in disciplinary actions. I also understand that I must return all school issued uniforms and pay for any damages that I may have done to uniforms or equipment. I will conduct myself in an appropriate manner at all athletic events and show my La Pietra School Pride at all times. I understand that if I quit or am dropped from a team because of disciplinary actions, grades, or absences, I'm ineligible to participate in any La Pietra Sports for one year to the date. I have not violated any eligibility rules and regulations of the Interscholastic League of Honolulu.

(student-athlete signature)

(date)

(parent/guardian signature)

(date)



Emergency Contacts & Emergency Medical Authorization

Student Last Name

Student First Name

Date of Birth

Parent Information

	First and last name	Cell Number ###-###-####	Alternate Number
Father/Guardian			
Mother/Guardian			

Emergency Contacts. In case parents are not reachable.

First and last name	Cell Number ###-###-####	Relationship: grandfather, grandmother, uncle/aunt, friend

€ Yes € No Does your daughter have Asthma?

€ Yes € No Can your daughter be given Tylenol for injuries?

€ Yes € No Is your daughter currently on medication? Specify reasons:

List past injuries or health concerns to be aware of:	
Insurance name:	Policy number:

Emergency Medical Authorization. I hereby give consent for medical treatment deemed necessary by physicians designated by the coach(es) and/or transportation to a hospital emergency room for treatment for any illness or injury resulting from her participation. I understand this authorization will only be enforced when I cannot be contacted and immediate treatment is needed.

Parent's name (print)

Parent's signature

Date



ImPACT Concussion Management Program

It is mandatory for all student-athletes participating in the ILH sports on La Pietra and Pac-5 athletic teams, to complete the ImPACT Concussion Management Baseline Testing. This school year Baseline testing will only be required for sixth, seventh, ninth, and eleventh grade student-athletes (and new participants) participating in the ILH.

The ImPACT program baseline test that will be administered by the athletic department staff will assist us in evaluating and treating head injuries (e.g. concussions). In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of the head injury and when the injury has fully healed.

After a concussive injury, the injured athlete is reassessed and the scores are compared to the baseline score. Athletes will only be considered to return to their activities if the post-injury scores are comparable to the baseline score. Although our goal is to test all athletes prior to the tryouts for each season, we may be administering the tests during the season due to limited resources of computer technology and human monitors and due to the challenge of testing a large number of athletes.

The non-invasive ImPACT test is set up in “video-game” type format and takes about 20-30 minutes to complete. It is simple, and many athletes enjoy the challenge of taking the test. Essentially, the ImPact test is an athletic physical exam of the brain. It tracks information such as memory, reaction time, speed, and concentration. It is not an IQ test.

If a concussion is suspected, the athlete will be required to retake the ImPACT tests. Both pre-injury and post-injury test results are evaluated by Pac-5 athletic trainers if they are on a Pac-5 team or your family physician who consults with a neuro-psychologist /neurologist as part of the evaluation process. The information gathered should also be shared with your family doctor. The test data will enable health professionals to determine when returning to play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all details. The information gathered from the ImPACT program may also be utilized in studies conducted by this school, the ILH, the University of Hawaii, local physicians, neuropsychologists, the State of Hawaii Department of Education and the National Athletic Trainers’ Association. In order to ensure your child’s anonymity, we have set up an anonymous data submission system. This data may anonymously be submitted for research purposes.

We wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. Please sign the bottom of this page with the appropriate signatures. For more information about concussions please visit NFHSlearn.com and take the free course *Concussion in Sports*. If you have further questions regarding this program please contact the Athletic Office (922-2744).

Student-athlete Name

Grade

(parent/guardian signature)

(date)



Pre-ImPACT Concussion Worksheet

Student Last Name	Student First Name	Date of Birth	Gender: Female
<input type="checkbox"/> Right <input type="checkbox"/> Left			
Height (ft., inches)	Weight (lbs)	Handedness	Place of Birth: Languages: 1 st :
		2 nd (if fluent):	

Ethnicity:

Years of education completed, excluding Kindergarten	<input type="checkbox"/> Freshmen	<input type="checkbox"/> Sophomore	<input type="checkbox"/> Junior	<input type="checkbox"/> Senior
In school, what type of student are you?	<input type="checkbox"/> Below Average (C – D)	<input type="checkbox"/> Average (B – C)	<input type="checkbox"/> Above Average (A – B)	

Circle any of the following that apply to you:

- | | | |
|-----|----|---|
| Yes | No | Receive speech therapy |
| Yes | No | Attended special education classes |
| Yes | No | Repeated one or more years of school |
| Yes | No | Diagnosed with a learning disability |
| Yes | No | Diagnosed with attention deficit disorder (ADD) or hyperactivity (ADHD) |

Have you had experienced treatment for:

- | | | |
|-----|----|---|
| Yes | No | Headaches by physician |
| Yes | No | Migraine headaches by physician |
| Yes | No | Epilepsy or seizures |
| Yes | No | Brain Surgery |
| Yes | No | Meningitis |
| Yes | No | Substance or Alcohol abuse |
| Yes | No | Psychiatric Condition (depression or anxiety) |

Have you ever been diagnosed with any of the following conditions?

- | | | | | | | | | |
|-----|----|--|-----|----|----------|-----|----|--------|
| Yes | No | ADD / ADHD | Yes | No | Dyslexia | Yes | No | Autism |
| Yes | No | Have you participated in any strenuous exercise or practice in the last 3 hours? | | | | | | |

- | | | |
|--------------|----|-----------------------------------|
| Yes | No | Are you currently on medications? |
| Please list. | | |

Hours of sleep last night:

Yes No Have you ever been diagnosed with a Concussion? If yes, answer the following questions:

Number of times diagnosed with a concussion, excluding current injury:

Total number of concussions that resulted in:

	Loss of consciousness		Difficulty with memory for events occurring immediately before injury
	Confusion		
	Difficulty with memory for events occurring immediately after injury		Total games missed as a direct result of all concussions combined

Month/year of 5 most recent concussions:

Current Sport(s):		Current position/weight class	Yrs of past High School Experience
1.	<input type="checkbox"/> Inter <input type="checkbox"/> JV <input type="checkbox"/> Vars		
2.	<input type="checkbox"/> Inter <input type="checkbox"/> JV <input type="checkbox"/> Vars		
3.	<input type="checkbox"/> Inter <input type="checkbox"/> JV <input type="checkbox"/> Vars		