CHRIST SCHOOL

AN EPISCOPAL SCHOOL FOR BOYS

HEALTH FORM *DUE JULY 1, 2013* (REQUIRED INFORMATION)

Student Name: Date of Birth: Student's SSN:_____

Allergies to Food/Environment: **Y/N *Dietary Restrictions: **Y/N** **Drug Allergies: **Y/N**

Student's Cell: Primary Physician Name: _____

Primary Physician Office Phone #:_____

*List Dietary Restrictions:

**List Drug/Food/Environment Allergies:

Parent(s)/Guardian(s) Contact Information:

1. Name: Home #: Cell #:

Work #: Email:

2. Name: Home #: Cell #:

Work #: Email:

Emergency Contact Information if parent/guardian is unavailable:

1. Name: Telephone #: Cell #:

2. Name: Telephone #: Cell #:

Parent's Billing Address:

Street Address City State Zip

AUTHORIZATION FOR MEDICAL TREATMENT/IMMUNIZATIONS:

In the event of an accident or illness, I hereby authorize Christ School personnel to act on my behalf as the legal guardian for the student named above in the securing of medical, surgical, psychiatric, and/or dental treatment. In the event of an emergency, I hereby give permission to the physician, nurse, hospitals, hospital staff, emergency medical/rescue squad, local urgent care center, and doctor's office selected by Christ School nursing staff / personnel to act on my behalf. I authorize Christ School to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for the student named. I certify that I am the parent or have the legal ability to sign these authorizations on behalf of the student named above. I consent to the release of information to Christ School and to the insurance company. I am financially responsible for all medical treatment and release Christ School from any financial liability.

Parent(s)/Legal Guardian(s) name (please print):

Parent(s)/Legal Guardian(s) signature: Date:

REQUIRED INSURANCE INFORMATION

PLEASE ATTACH A COPY OF BOTH SIDES OF MEDICAL/DENTAL/RX INSURANCE CARDS

Primary Insurance Cardholder's (*PIC*) Name:

PIC*'s DOB**: ***PIC*'s SSN #** ***Group ID:

(Please update if expires)

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HOST FAMILY/VISITATION MEDICAL CONSENT FORM

(ALL must read and sign)

I _____ (please print name), parent/guardian give my permission for a host family to receive my son's medical/treatment authorization form for the purpose of receiving medical treatment in the absence of parent/guardian in the event of accident or injury when away from Christ School.

Parent(s)/Legal Guardian(s) name (please print): _____

Parent(s)/Legal Guardian(s) signature: _____ Date: _____

Student's Name: _____

REQUIRED CREDIT CARD INFORMATION:

For use in Medical/Dental visits, Prescriptions, Co-payments: Please note that this information will be kept confidential in the student's medical file. **Please update if this information expires!**

Please circle card type: **VISA** **MasterCard** **Discover**

Primary Credit Cardholder's Name:_____

Account Number:_____

Expiration Date:_____ **3 Digit security code on back of card:**_____

Billing Address:

Name:_____ **Street Address:**_____

City:_____ **State:**_____ **Zip:**_____

Office Use Only:

Please use this area to attach receipts from all charges and date of charge.

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CONFIDENTIAL INFORMATION
(TO BE KEPT ONLY IN MEDICAL FILE)

Student Name: _____

Has your son been evaluated/diagnosed with a learning disability? Y / N
If yes, please give diagnosis and explain:_____

_____

_____

_____

Is there anything else, health related, that would be helpful for us to know about your son? This can include, but is not limited to, any suggestions that may facilitate his medical care and/or adjustment to school:

_____

_____

_____

_____

_____

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MEDICATION POLICY AND PROCEDURE ACKNOWLEDGEMENT

1. All medication will be provided by Cane Creek Pharmacy. No prescription medication or over the counter medications will be permitted in my son's room (excluding emergency inhalers, face creams, epipens, & insulin). Non-compliance in taking prescribed medications will result in the nurse reporting the behavior to the Student Life Office.

2. It is my responsibility to ensure my son's MD will mail and/or fax all prescription orders to Cane Creek Pharmacy. The pharmacy will then file with my insurance company and secure new scripts from the MD for refills as needed.

3. Students may not transport controlled substances unless parent assumes full responsibility and provides written permission for student to transport (see #4 for this signature). When students are being transported by Christ School shuttle or Christ School drivers, the driver will take prescribed medications to the destination and give the medication directly to parent/guardian. If student is traveling by air then the driver will transport his medication to the airport with the student and give the medication to the student at the airport. (This will only be permitted with written permission by parent or guardian prior to transport). Please sign here if you give your son permission to transport medications, in the methods stated above, from Christ School for breaks.
   Parent/Legal Guardian Signature:_____

4. I give permission for my son to assume full responsibility for and to transport his own medications for any off-campus breaks, including visits home and time with a host family.
   Parent/Legal Guardian Signature:_____

5. If my son is visiting with another family/sponsor over the weekend or during breaks, I give my permission for hosting families to receive medical treatment/release form, and medications prescribed for the duration of my son's visit to the host families' home, and follow through with care.

6. A Medication Authorization form will be completed and signed by a physician for each of my son's medications. All medications and changes in medication/ dosage **must be approved by the physician before being administered or discontinued.**

7. If for some extraordinary reason a medication must be sent to school, **mail directly to Attention: Wellness Center.**

8. **All medications that are not claimed by the parent at the end of the school year (May 31st) will be destroyed by a nurse from the Wellness Center. You will have a week's time to comply with this stipulation, as we cannot hold medication over the summer even if your student will be returning!**

9. I authorize the school nurse or designee to administer over the counter medications in accordance with Christ School Standing Orders.

10. I will refer to and comply with all other policies and procedures found in the Christ School Handbook related to Wellness Center Policies and Procedures.

11. I have received, read, and understand that Christ School Wellness Center has the right to change its Policies and Procedures, and Medication policies, at any time and provide notice to parents when applicable.

Parent(s)/Legal Guardian(s) name (please print):_____

Parent(s)/Legal Guardian(s) signature:_____ Date:_____

Student's Section

1. It is **MY** responsibility to go to the Wellness Center and take medications as prescribed by my regular physician, or other licensed physician. (i.e., Urgent Care, Emergency Room, etc.)

2. **NO** Medication or over the counter medication is permitted in **MY** room (excluding emergency inhalers, face creams, epipens, & insulin). If I am caught with medication in my room, I understand I will be subject to the discipline of the Director of Student Life.

Student signature:_____ Date:_____

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Student's Name:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

- I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my son's protected health information. I understand that this information can and will be used to:
    - Conduct, plan and direct my son's treatment and follow-up among the multiple healthcare providers, Christ School officials, Wellness Team members and GroupRx Pharmacy (upon occasion a faculty member, coach, or houseparent may need to be informed about a student's medication or condition) who may be involved in his treatment directly and indirectly.
    - Conduct related open communication (discussion of my son's medication and treatment regimen with the Wellness Team Members and/or counselor) when necessary for compliance/treatment issues. On occasion, an advisor, coach, and houseparent may need notification for continuation of care being provided.
    - Conduct normal healthcare operations such as treatment, assessment and physician referrals/exams. Diligent attempts will be made to first contact parent/guardian for approval of appointments. However, it is not necessary to wait for parent/guardian or emergency contact approval in case of emergency or delayed response from responsible parties.
- Wellness Center Staff may leave important information that relates to my son on our home/cellular and or personal answering machine.

You have my permission to leave messages with the following: (please list name(s), relationship(s), and phone number(s)):

1. _____

2. _____

3. _____

I have received, read and understand your Notice of Privacy Practices and medication procedures. I understand that Christ School Wellness Center has the right to change policies and procedures at their discretion and will notify parents/guardian of these changes.

Parent(s)/Legal Guardian(s) name (please print):_____

Parent(s)/Legal Guardian(s) signature:_____ Date:_____

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PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION

No medication will be administered without a physician's signature.
All medication changes must have a written order from an M.D.
Please update this form if there are any changes in status or dosage of medication!

Please Print:

Student Name: _____Date of Birth: _____

Physician's Name (please print): _____

Physician's Phone: _____ Fax Number: _____

Physician's Address:

_____

_____

Allergies:_____ Diagnosis: _____

Labs required? _____ Weight required? _____

Please denote if any medications are new below (or started within the last month).

Medication	Dose	Times Given
1.		
2.		
3.		
4.		
5.		

Please Check One: School Days Only _____ Every Day_____

Date of Last Physician Visit: _____ Follow up Due:_____

Physician's Signature: _____ Date: _____

Christ School Wellness Center
500 Christ School Road Arden, North Carolina 28704-9914
Phone: 828-684-6232 ext. 139 • Fax: 828-684-7219
Email: nurse@christschool.org

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ANNUAL PHYSICAL EXAM (REQUIRED FOR ENROLLMENT) DUE JULY 1, 2013

Student Name: _____**DOB:**_____ **Date of Examination:**_____

VITALS	SATISFACTORY YES	SATISFACTORY NO	PHYSICAL EXAMINATION COMMENTS	RECOMMENDED FOLLOW-UP
HEIGHT				
WEIGHT				
BP_____ GENERAL URINE Sp. Gr. _____ Glucose _____ Protein _____ Hgb/Hct _____				
HEAD				
EYES			ACUITY R L	
ENT				
DENTAL				
CHEST				
HEART				
ABDOMEN				
GENITALIA				
SKIN				
EXTREMITIES				
BACK, NECK				
ALLERGY				
SUMMARY OF COMMENTS:				

1. **List all Hospitalizations with Diagnosis and Dates**: _____

_____

Are you licensed to practice medicine in the United States? Yes_____ No_____

Physician's printed Name and Address or stamp: _____

Telephone Number: _____ **Fax:** _____ **Email:** _____

BY SIGNING THIS ANNUAL PHYSICAL FORM, I AM CONSENTING TO NO RESTRICITONS/CONDITONS TO STUDENT'S PARTICIPATION IN SCHOLASTIC/SPORT ACTIVITIES.

Signature of examining Physician: _____ **Date:** _____

(use back of form for additional explanation)

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History of Infectious Disease

Please give age at which student was infected:

Scarlet/Rheumatic Fever	_____	Tuberculosis	_____
Chicken Pox	_____	Mononucleosis	_____
Malaria	_____	Other: _____	_____

Health History

Has the student had any of the following? If so, please check and explain below:

Chest X-Ray	_____	Allergies	_____
Serious injury or fractures	_____	Significant food allergies	_____
Concussion? List #/dates below	_____	Reactions to injections	_____
Surgery	_____	Back or knee problems	_____
Passed out during or after exercise	_____	Psychiatric or psychological	
Dizzy during or after exercise	_____	problems or treatment	_____
Chest pain during or after exercise	_____	Other: _____	_____

Please check and explain below. If more space is needed, use the back of this form:

Frequent colds	_____	Heart condition	_____	Stomach upsets/ulcer	_____
Sore throats	_____	Seizures	_____	Urinary problems	_____
Sinusitis	_____	Diabetes	_____	Arthritis	_____
Ear problems	_____	Family history of		Skin diseases	_____
Asthma	_____	diabetes	_____	Acne	_____
Hay fever	_____	Depression	_____	Jaundice	_____
Bronchitis	_____	Anxiety	_____	Blood disorders	_____
Testicular problems	_____	ADD/ADHD	_____	Sickle cell carrier/positive	_____

Eyes (required)

Student's eyes have been examined with the following results:

Vision	Near	Distant	Corrected to:	Near	Distant
Right:	_____	_____	Right:	_____	_____
Left:	_____	_____	Left:	_____	_____

Orthodontics

Has there been any extensive dental correction or orthodontics? If so, please give details:

Type of orthodonture:_____

If student is continuing orthodonture, please give name, address, and phone number of orthodontist:

_____

Will the student require orthodontic care while at Christ School? **YES**_____ **NO**_____

If yes, please give name of orthodontist in Asheville, if known _____

Date of next appt in Asheville _____ Date of last visit to orthodontist _____

Are there any specific activities to be **encouraged** or **restricted**? Please give details.

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Immunization Record—Due July 1, 2013

(PLEASE ATTACH COPY OF OFFICIAL IMMUNIZATION RECORD!!!)

PLEASE LIST MONTH, DAY, AND YEAR FOR ALL DOSES: *RETURNING STUDENTS-LIST ANY BOOSTERS/SERIES GIVEN IN LAST YEAR.

Student's Name_____

NC STATE LAW—A STUDENT MAY NOT REGISTER WITHOUT COMPLETE IMMUNIZATION SERIES & HISTORY—NC STATE LAW

Vaccine	Date	Date	Date	Date	Date
DTP or DPT—5 *Required* No 5th dose if 4th dose was after 4 yrs old					
Td or Tdap Booster *Required*			XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX
OPV/IPV *Required*					XXXXXXXX XXXXXXXX
MMR #1 & MMR #2 *Required*			XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX
HEPB 1, 2, & 3 *Required*				XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX
Hib <5 years age					XXXXXXXX XXXXXXXX
Varicella *Required*			**Date of disease:**	XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX
Flu Vaccine *Recommended*					
PPD-(*tuberculosis*) ***Required for students who have traveled out side the country in the last year and annually for international students.*****		**Chest X-ray Indicated? Yes__ No__ MD initial____**	****See nurse for more details about foreign travel.**		
Meningitis (MCV-4) *Recommended*			XXXXXXXX XXXXXXXX	XXXXXXXXX XXXXXXXXX	XXXXXXXX XXXXXXXX

Physician's Signature: _____ **Date:** _____

Flu Vaccine (Please Check One):

_____ **Yes, I do want my son** _____ **to receive the flu vaccine at Christ School, if available.**
Student Name

_____ **No, I do not want my son** _____ **to receive the flu vaccine at Christ School.**
Student Name

Parent's Signature: _____ **Date:** _____

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Over the Counter/ Stock Medications

Student's Name:_____

The following over-the-counter (OTC) and stock medications are commonly administered from the Wellness Center. Please have your regular physician indicate medications cleared for administration by INITIALING beside each medication. These medications will only be administered in the below dosage ranges unless otherwise indicated by the prescribing physician.

OTC

_____ **Acetaminophen 500mg** (Tylenol) – Take 2 caplets every 4-6 hours as needed for pain or fever

_____ **Bismuth Subsalicylate 262mg** (Pepto-Bismol) **–** Chew or dissolve 2 tablets in mouth for relief of diarrhea, indigestion, upset stomach, heartburn, or nausea; repeat every ½ hour to 1 hour as needed; not to exceed 8 doses in 24 hours

_____ **Diphenhydramine 25mg** (Benadryl) **–** Take 1 – 2 capsules every 4 – 6 hours as needed for allergic reaction or symptoms related to hay fever or other respiratory allergies

_____ **Guaifenesin 200 mg**– Take 1-2 tablets every 4 hours for relief of cough; do not exceed 6 doses in a 24-hour period

_____ **Ibuprofen 200mg** (Advil/Motrin) **–** Take 2 tablets every 4 - 6 hours while symptoms persist for pain or fever; do not exceed 6 tablets in 24 hours

_____ **Loperamide 2mg** (Imodium) – Take 2 capsules initial dose and 1 capsule after every loose stool (not to exceed 16mg (8caps) in 24 hours)

_____ **Loratadine 10mg** (Claritin) **–** Take 1 tablet every 24 hours as needed for relief of upper respiratory symptoms

_____ **Maalox/Mylanta –** Take 2 – 4 teaspoons 2 times a day as needed for GI upset, acid reflux, indigestion

_____ **Nasal Decongestant PE 10 mg** (Phenylephrine Hydrochloride) **–** Take 1 tablet every 4 hours for the relief of sinus congestion and pressure

_____ **Tums 500 or 750 mg tabs** (Calcium Carbonate) **–** Chew 2 tablets as needed for acid indigestion, heartburn

_____ **Tussin DM** (Dextromethorphan, HBR 10mg, Guaifenesin, USP 100mg) – Take 2 teaspoons every 4 hours for relief of cough when suppressant is needed; do not exceed 6 doses in a 24-hour period

_____ **Vitamin C 500mg –** Take 1 tab every day as needed

Stock

_____ **Tylenol with Codeine Elixir (**Acetaminophen 120mg/Codeine phosphate 12mg) – Take 1tsp every 4-6 hours as needed for incessant coughing (Prescribed by Dr. Kevin Treakle, consulting physician)

_____ **Zofran (Ondansetron ODT) 4mg –** Dissolve one tablet orally every 6 hours by mouth if needed for moderate nausea and vomiting (Prescribed by Dr. Kevin Treakle, consulting physician)

Physician's Signature: _____Date:_____

Parent's Signature: _____Date:_____