CHRIST SCHOOL

AN EPISCOPAL SCHOOL FOR BOYS

MEDICAL TREATMENT FORM

Student Name: **Date of Birth:**

Student Cell#: **SSN#:**

Drug allergies: **Reaction:**

Food allergies: **Dietary restrictions:**

Seasonal/environment allergies:

Primary MD: **Contact Phone Number:**

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 #:

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/Guardian(s) name (print): sign: date:

Parent/Guardian(s) name (print): sign: date:

Billing Address City State Zip

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:

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 card changes or 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:_____

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

_____

_____

_____

_____

_____

Has your son been evaluated/diagnosed with a learning disability? Y / N

If yes, please give diagnosis and explain:_____

_____

_____

_____

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MEDICATION POLICY AND PROCEDURE ACKNOWLEDGEMENT

1. **No prescription medication or over the counter medications will be permitted in my son's room (excluding emergency inhalers, Epi-pens, face creams, & insulin). Non-compliance will be reported 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 the pharmacy. It is also **MY** responsibility to provide accurate insurance and billing info, including credit card to the pharmacy, for prompt and timely dispensing.

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 responsibility for picking up meds and bringing to the destination. 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 if needed, 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 a medication must be sent to school, **please mail directly to Attention: Wellness Center. Please do not send to your son's address.**

8. **All medications not claimed by the parent at or before graduation will be disposed of properly through our school pharmacy. We cannot hold medications over the summer even if your student will be returning!**

9. I authorize the school nurse or faculty chaperone to administer over the counter medications in accordance with Christ School Standing Orders, as well as, any prescribed medications on any extended school trips.

10. I have received, read, and will comply with the Wellness Center policies and procedures found in the Christ School Handbook. I understand that Christ School has the right to change its policies and procedures 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., antibiotics from Urgent Care, Emergency Room, etc.)

2. **NO** Medication or over the counter medication is permitted in **MY** room (excluding emergency inhalers, Epi-pens, face creams, & insulin) unless packed by the nurse. If I have 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 Name: _____ **Date of birth:** _____

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, 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 home/cellular and or personal answering devices.

May provide health information to 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. I understand 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

All prescription medications require a physician's order and signature.
Medication changes (including discontinuance) require a written order from the physician.
(Please use this form for all new orders and changes.)

Student Name (print): _____Date of Birth: _____

Physician's Name (please print): _____

Physician's Phone: _____ Fax Number: _____

Physician's Address: _____

Allergies:_____ Diagnosis: _____

Labs required? _____ Monthly weight check: _____

Medication	Dose	Times to be taken	Daily or School Days only
1.			
2.			
3.			
4.			
5.			

***Please denote any medications started within the last month.**

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 x 139 Fax: 828-684-7219
Email: nurse@christschool.org

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Immunization Record

Student Name: _____ Date of birth: _____

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	**1st**	**2nd**	**3rd**	**4th**	
TD or DT Booster *Required*	**11-12 yrs (5 yrs after 5th DTP/TDap)**	**Every 10 years**	**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**
Varicella *(2 doses required if born after 4/01/01*			**Date of disease:**	**XXXXXXXX XXXXXXXX**	**XXXXXXXX XXXXXXXX**
Flu Vaccine *Recommended*					
PPD-(*TB) Required for students who have traveled out of the country more than 30 days this past year, unless previously positive.*	**PPD _____ Date _____** *(previously positive, see TSPOT/CXR)*	**TSPOT indicated? Yes__ No__ MD _____**	**Chest X-ray Indicated? Yes__ No__ MD _____**	**Additional notes: _____ _____ _____**	**_____ _____ _____**
Meningitis (MCV-4) *Required*			**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: _____

STUDENT NAME:_____

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Over the Counter/ Stock Medications

Parents, please initial each OTC medication your student may take at school and sign below.

_____ **Acetaminophen 325-500mg** (Tylenol) – Take 1-2 caplets every 6 hours as needed for pain or fever.

_____ **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, take with food

_____ **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

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

_____ **Phenylephrine HCL 10mg** (decongestant**) –** Take 1 tablet every 4-6 hours for the relief of sinus congestion and pressure**.**

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

_____ **Tussin DM** (Dextromethorphan, HBR 10mg, Guaifenesin, USP 100mg) – Take 1-2 teaspoons every 4-6 hours for relief of cough when suppressant is needed; do not exceed 4 doses in a 24-hour period

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

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

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

_____**Ranitidine 75mg** (Zantac) – Take 1 tablet, 30 minutes before meal twice daily for persistent indigestion or reflux symptoms.

Parent signature_____Date_____

Below medication may be ordered PRN by your physician for moderate to severe nausea and vomiting.

_____ **Zofran (Ondansetron ODT) 4mg –** Dissolve one tablet orally every 6 hours by mouth if needed for moderate nausea and vomiting.

Physician's Signature: _____ Date:_____

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ANNUAL PHYSICAL EXAM

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

EXAM		PHYSICAL EVALUATION COMMENTS	Follow-up
HEIGHT:			
WEIGHT:			
BP (sitting):	**(standing):**		
PULSE:	**RR:**		
LAB/URINE			
Sp. Gr.			
Glucose	Protein		
Other			
LAB/BLOOD			
Hgb/Hct			
Glucose Other			
HEAD			
EYES (required)		**Acuity: _____(R)_____(L)**	
ENT			
DENTAL			
CHEST			
HEART			
ABDOMEN			
GENITILIA			
SKIN			
EXREMITIES			
BACK,NECK			
Other			

DRUG ALLERGIES:

FOOD ALLERIES:

DIET RESTRICTIONS:

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 or CONDITONS TO STUDENT'S PARTICIPATION IN SCHOLASTIC/SPORT ACTIVITIES.

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

(Please review Student/Family Health History, next page)

Student Name: _____DOB:_____ Date:_____

Student/Family Health History

(To be updated annually by parent/guardian; copy to MD for exam.)

Has your child ever experienced any of these events? If so, please list date, treatment, or hospitalization required.

1. Severe allergic reaction _____
2. Concussion (list all) _____
3. Passed out or had a seizure_____
4. Experienced chest pain or dizziness_____
5. Severe shortness of breath with exercise_____
6. Sustained a serious injury_____
7. Fracture _____
8. Surgery_____
9. Emotional trauma or loss_____

Other_____

Has your child regularly experienced or had any of these conditions or illnesses? What treatment is normally required?

10. Headaches, migraines _____
11. Colds, ear, or throat infections _____
12. Strep or mono _____
13. Seasonal allergies, sinusitis _____
14. Asthma, bronchitis _____
15. Indigestion, nausea, acid reflux _____
16. Irritable bowel, diarrhea/constipation _____
17. Bladder or testicular problems _____
18. Joint or muscle pain _____
19. Eczema, rash, shingles, ringworm _____
20. Nervousness, anxiety, depression _____
21. Weight loss/gain of concern _____

Other _____

Is there any family history:

22. Low/high blood sugar, diabetes_____
23. Blood disorder, sickle cell anemia/carrier_____
24. Irregular heart rhythm, mitral valve disorders_____
25. Underactive/overactive thyroid_____

Other_____

Dental/Orthodontics

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

_____

Dentist/Orthodontist contact info:_____

Other important information

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

_____