

Physical and Medication Forms Due August 3, 2011

No student can attend class without the medical forms submitted. Students who have not fulfilled this requirement will be sent home.

Physical Form

Complete immunizations records must be included on a physical form signed by a physician within the past 12 months for all students.

You may use the form your doctor supplies for the physical or the school health record in the packet.

Medication Forms

There are two forms that are necessary for the school nurse to administer daily medication to your child. The physician who orders the medication must fill out the order form. The parents must fill out the parental permission form. If a student starts medication during the year, the parents have 3 days to return the forms from the start of medication, after which the school nurse will stop giving the medication until both forms are returned to the school.

Short-term medication will be administered if it is sent to the school in the correctly labeled pharmacy bottle with instructions from the parent as to the time and days it is to be given. No forms are necessary for short-term medications.

Inc.: Parent Authorization
Medication Order Form
Health Record
Certificate of Immunization

Telephone: 781-259-8342
Fax: 781-259-8852

Carroll School

Baker Bridge Road
Lincoln, Massachusetts 01773

September 2011 EMERGENCY PERMISSION FORM AND HEALTH HISTORY

Child's Name _____ Date of Birth _____

Please list all known allergies: Describe reaction and management of reaction:

Allergy:	Reaction and Management:

Is an Epinephrine pen prescribed? Yes ___ No ___ If yes, reason _____

Please check information that applies to this child's medical history:

Asthma	Seizures	Chicken pox	Meningitis
Headaches	Diabetes	Measles	Encephalitis
Ear infection	Kidney Disease	Mumps	Lyme Disease
Tonsillitis	Hernias	Rubella	Serious Accidents
Menstrual cramps	Operations	Scarlet Fever	

Vision, hearing, speech or orthopedic problems, etc.?

Glasses	Near sighted	Far sighted	Contact Lenses
Hearing aid	Other		

Is Your Child on any prescribed Medication?

Medication	Dosage	Times/Day
Medication	Dosage	Times/Day
Medication	Dosage	Times/Day

Yes ___ No ___ I give permission to the Carroll School nurse or her designee to administer Tylenol or Advil (dosage appropriate to age) to my child. I agree to indemnify the Carroll School and its agents against all claims as a result of any and all acts under this authorization.

Important – This box must be completed for attendance

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all school activities except as noted.

I hereby give permission to the Carroll School to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission for the Carroll School to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Carroll School to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of the Carroll School.

Signature of parent or guardian _____

Printed Name _____ Date _____

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History

Pertinent Family History

Current Health Issues

Y **N**
 Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: Yes No
 Asthma: Asthma Action Plan Yes No (Please attach)
 Diabetes: Type I Type II
 Seizure disorder: _____
 Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination

Date of Examination: _____

Hgt: _____ (____%) Wgt: _____ (____%) BMI: _____ (____%) BP: _____

(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

(Pass) (Fail)
Vision: Right Eye
Left Eye
Stereopsis

(Pass) (Fail)
Hearing: Right Ear
Left Ear

(Pass) (Fail)
Postural Screening:
(Scoliosis/Kyphosis/Lordosis)

Laboratory Results: Lead _____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: ____; Results: ____ mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations: _____

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

Y N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date _____

Please print name of Examiner.

Group Practice _____ Telephone _____

Address _____ City _____ State _____ Zip Code _____

Please attach additional information as needed for the health and safety of the student.

MDPH 06/13/11

Carroll School
Parent/Guardian Authorization for Prescription Medication Administration

Student's name _____ Date of Birth _____

Parent/Guardian printed name _____

Telephone number – Home: _____

Telephone number – Work: _____

Telephone number – Cell: _____

Other person(s) to be notified in case of medical emergency:

Name: _____ Telephone number: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

My son/daughter has the following food or drug allergies: _____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

Yes _____ No _____

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian signature _____ Date _____

Relationship to Student _____

Address _____

Carroll School
Medication Order Form to be completed by a licensed prescriber

Name of Student _____ Date of Birth _____

Address _____ Grade _____

Name of Licensed Prescriber _____ Title _____

Business Telephone _____

Emergency Telephone _____

Medication _____

Route of Administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Specific directions or information for administration: _____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:

2. Other medication being taken by the student:

3. The date of the next scheduled visit or when advised to return to prescriber:

4. Consent for self-administration (provided the school nurse determines it is safe and appropriate).

Yes _____ No _____

Signature of Licensed Prescriber _____ Date _____

*if not in violation of confidentiality