MANDATORY HEALTH DOCUMENTATION GUIDELINES
伍德斯托克学院健康文件准则

Dear Parent / Guardian,
亲爱的家长或监护人，

Please note that all health office paperwork MUST be completed and mailed, faxed, or emailed to the health office at least 2 weeks prior to registration at The Woodstock Academy. All forms MUST be completed in English. 请注意: 所有的文件都必须要在注册前至少两周邮件或传真至学校医务室。所有的文件都要用英文填写完成。

Emergency Medical Consent – Please write names and addresses in English and be sure to sign both areas at the bottom of the form. 紧急医疗同意书：请用英文写下姓名和地址，并确认在同意书最下方签名。

Insurance- All international students must have The Woodstock Academy recommended or equivalent student health insurance. The Woodstock Academy will provide copies of insurance cards to local providers. If you have chosen an alternate health insurance plan for your son/daughter then please provide a front and back copy of the insurance card along with the health packet. 医疗保险：所有的国际学生都必须购买学校推荐的保险或是同等类型的学生健康保险。校方会向地方医疗机构提供学生的保险卡复印件。如果您为您的孩子选择了同等类型的医疗保险，请随同其他医疗表格向学校提供医疗卡的正反面复印件，和保险内容。

Physical – A medical physical must be performed with the form completed by a doctor /provider in your home country. We must have a new physical completed each school year. (Dated June 2020 or later) Students will not be allowed to participate in any sport or off campus activity until a current physical is on file in the health office. 健康检查：健康检查表格须由所在国家/地区的医生/医疗服务提供者以英文完整填写。每个学年我们必须完成一次新的体检。(日期须在 2020 年 6 月之后)。在学校医务室有完整地存档之前，学生将不被允许参加任何体育活动或校外活动。

*Be sure that your child's name, date of birth and any allergies are clearly written at the top of the physical form. *请确定您的孩子中英文姓名、生日及任何过敏历史都需准确完整地填写在表格上。
Immunizations – All immunizations must be completed and up to date as follows:
疫苗：所有的疫苗都需要在以下日期完成施打

- DTP (Diphtheria, Tetanus, Pertussis): Minimum of 4 doses with at least one dose on or after the 4th birthday. If series started after age 7, then only a total of 3 doses is needed.
  DTP (白喉，破伤风，百日咳疫苗) 至少需要 4 剂，其中有一剂需要在 4 岁或 4 岁以后接种。如果在 7 岁以后开始接种，那么只须 3 剂。
- Tdap (Tetanus / Pertussis) 3 single dose between the ages of 11-18.
  Tdap (破伤风/非细菌性百日咳疫苗)在 11 和 18 周岁之间接种 3 剂。
- Polio – At least 3 doses (the last one given on or after the 4th birthday).
  小儿麻痹-至少 3 剂 (最后一剂需要在 4 周岁生日或之后接种)
- MMR – (Mumps, Measles, Rubella) 2 Doses separated by at least 28 days (1st dose on or after the 1st birthday).

MMR(麻疹、腮腺炎、德国麻疹)两剂(两剂之间需要间隔 28 天，其中一剂需要在一周岁或一周岁之后接种)

- Hepatitis B – 3 doses (completed within a 6 month period).
  B 性肝炎-3 剂 (在 6 个月之内完成)
- Varicella (chicken pox) – Verification of disease (confirmed in writing by Dr.) or
  水痘-患病证明(医生签署)或
  - 2 doses separated by at least 4 weeks for any unvaccinated student, or
    任何未接种学生需要 2 剂疫苗，其间隔 4 周以上，或
  - 2 doses separated by 3 months on or after the 1st birthday.
    一周岁以后接种，两剂相隔 3 个月。
- Meningococcal Vaccine – At least 1 for all boarding students before entry into high school.
  脑膜炎球菌疫苗-所有的寄宿学生在入校以前都须接种 1 剂。

PPD / Mantoux (dated within 1 month prior to the 1st year at The Woodstock Academy. If it is positive (Equal to or greater than 10 mm) a chest x-ray must be done. Prophylactic treatment is to be considered.
结核菌素试验(所有的新生都必须在入校前至少一个月接种 1 剂)。若为阳性(等于或者大于 10mm)则需要胸腔 X 光测试，如有需要则要药物治疗。

Personal Medical History – Must be completed and signed each year. 个人医疗历史-每年都须检查和签名。
Student Health Calling Information Form-Must be completed and signed each year. 学生健康呼叫信息表 - 必须每年填写并签字。
Medication Authorization Form – Must be completed and signed each year. 用药授权书-每年都需要检查和签名。
Physicians Request for Medication Administration Form-No medication, vitamins, or supplements will be administered without a doctor's written order. 处方药物管理表格 – 若没有医生的英文书面医嘱，学校医务室就无法对学生使用任何药物，维生素或补充剂。

FLU Immunization Consent – If you wish for your child to receive the flu vaccine in October, please complete and sign the form. (Not mandatory but highly recommended). 流行性疫苗注射同意书-若您同意您的孩子 10 月份在校接种流感疫苗，请完成并且签署同意书。（自愿为主，但学校强烈建议接种）

Please put your child's full name on all health documents
请在所有健康表上签上您孩子的中英文全名

The Woodstock Academy
57 Academy Rd.
Woodstock, CT 06281
Phone: 860-928-6575, Fax: 860-928-0313, 电邮：bsaucier@woodstockacademy.org

THE WOODSTOCK ACADEMY MEDICATION POLICY
伍德斯托克学院医药规范

Students who have valid medical needs for medication at school will be administered medication under the supervision of a school nurse or other school personnel, if the following conditions are met:
学校会将药定时发配给需要服用处方药的学生，但是他们必须在学校医护人员或者其它工作人员的监督下进行服用，同时他们必须符合以下每一条件：

1. Student will be evaluated by his/her prescribing physician at least once annually.
   学生至少由他/她的医生每年进行体检一次。
2. Medication must be sent directly to the Health Center in the original container, clearly labeled with the name of student and medication on it. The Health Center will not accept improperly labeled containers.
   所用药物都必须装在原装药瓶或包装盒内，并且清楚的表明学生中英文姓名，直接送到学校医务室内。学校医务室不会接受任何标注不明的药物容器。
3. All students are to receive adequate instruction from the prescribing physician regarding the self-administration, desired effect, and side effects of all medications.
   所有学生都应该遵循医生的指导服药，学生应该已经从医生那里得知药物的疗效和副作用等。
4. A Physician's Request for Medication Administration form must accompany all prescription and non-prescription medications (including vitamins, supplements, and homeopathics). The Woodstock Academy does not allow the use of any products containing creatine or nicotine, this includes protein shakes. All forms must be signed and dated by the prescribing physician. The written order must be renewed yearly and/or when there are any changes in medication, dosage, or time of administration. Medications cannot be prescribed by parents who are physicians.
   所有的处方和非处方药（包括维生素和滋补药）都必须伴有医生的英文同意书。伍德斯克学校不允许学生服用任何含有氨基酸或尼古丁的药物，其中包括蛋白质粉。所有的英文同意书必需伴有医生的亲笔签名并标注日期。当所用药物，药物剂量或服用时间发生改变时，医生必需提供新的同意书，除此之外同意书应该每年更新一次。
5. A Medication Authorization form must be completed and signed by the parent(s) and student.
   家长和学生必须在药物授权表上签名。
6. No medications or supplements are allowed in student rooms without Health Center authorization.
   未经学校医务室允许，任何学生不得在自己寝室内存放任何药品或滋补类药物。

NON-COMPLIANCE WITH MEDICATIONS 违返用药规定

Medication non-compliance will be dealt with on an individual basis and in conjunction with the Dean's Area. Be aware that the Health Center does not do mouth checks. 违反医药规范的学生将在训导处的监督下根据个人情况进行个别处理。请注意学校医务室不会让学生张开嘴检查他们是否已经吞下了药物。

PARENT/GUARDIAN RESPONSIBILITIES REGARDING MEDICATION:
父母/监护人关于药物治疗的责任：

1. The parent is responsible for obtaining all paperwork needed by the physician's office with respect to medications and other supplement/vitamin needs. 家长有责任提供所有从医院/医生开立的所用药物和其他补充/维生素需求方面相关的英文文件。

2. The parent will refill all prescribed medication monthly and send directly to the Health Center to ensure an adequate supply at all times. The medication will be in the original container and properly labeled. **The Health Center gives reminder calls as a courtesy only-this should not be relied upon.** (Remember to send all medication in original bottles that have been properly labeled) 家长需要每个月补给学生所需的药物并且直接寄送到学校医务室以确保学生有足够的剂量。所有药物必须在原装包装内并且拥有清楚的英文标注。基于安全考量，学校医务室会定期给家长电话通知药物补给，但是请家长不要完全依赖学校医务室的提醒。(请务必将所有药物都放入已正确标记的原包装里)
3. The parent will keep an adequate supply of medication at home or place of destination for all vacation break times. **The Health Center does not send medications home during fall, winter, and spring breaks unless they have been filled at our local pharmacy.** 家长需要确保自己家里备有足够的药物，在假期返家时也应备有学生需要的药物，学校学校医务室不会在暑假，寒假和春假的时候将药物寄回家, 除非次处方药物是由学校本地医生开立。
4. The parent is responsible for verifying that all medication authorization orders are written in English. Parents should work with the prescribing doctor to make sure that medication orders include name of the student, medication, dosage, route, frequency, and reason that it is being prescribed. All vitamins, supplements, and herbal medication must have the same written physician authorization orders. 家长应该负责核实所有药物授权书/医嘱均以英文书写。 家长应与处方医生合作，确保药来源包括学生姓名，药物，剂量，途径，频率和处方原因。 所有维生素，补充剂和中药粉/药丸都必须具有相同的英文书面医师授权书/医嘱。
5. All medications, supplements, vitamins, and herbal medication administered at school must be labeled in English. 学校管理的所有药物，补充剂，维生素和中药粉/药丸都必须用英文标注。若有必要，请自行另请专人翻译并公证再提供给学校，已确立所有医疗文件的公正合法性。
6. Parents should notify the health office directly if they do not want their child traveling home with medications during vacation periods or at the end of the school year.
若父母不希望孩子在休假期间或学年结束时带着药物回家，应直接通知学校医务室。
7. Parents are aware that any medication not picked up in the health office 2 weeks following school closing will be destroyed. 请家长们悉知，学校关闭后 2 周内所有尚在医务室待领回的任何药物都会被销毁。

STUDENT RESPONSIBILITIES REGARDING MEDICATION: 学生对于药物治疗的责任：

1. The student is to come to the Health Center for all prescribed medications at the proper times.
学生必须依照医嘱按时前来学校医务室服药。
2. The student is to alert the Health Center immediately if there are any questions or concerns with regard to their medication. 如果学生对自己所服药物有疑问或有不适症状，请立即通知学校医务室。
3. The student is to notify the Health Center of any off-campus events (sports, class trips, etc.) in which they will need medication packaged. If controlled medications are involved they must notify faculty to pick up their medication. 当学生需要离校参加活动时 (体育比赛，郊游等)，学生必须通知学校医务室准备好需携带的药物。如果涉及需监控的药物，学生必需通知教职人员前往领取。
4. The student will not have any prescription or over the counter medication/supplements in his/her room, or on his/her person without health center authorization. If the student does have medication, supplements, vitamins or herbal medication in their dorm room or packed luggage, they will turn it into the health office and work with the health office staff on appropriate approval. 学生在未获得学校医务室核准前，不得私自拥有任何处方药、非处方药或营养滋补药。若在学生在宿舍房间或行李中发现任何药物、补充剂、维生素或中药粉/药丸，会将其没收，直到在获得医务室医护人员检查核准。

5. Student is aware of the medication policy as it is written in the health office packet and student handbook and accepts disciplinary action if the policy is not followed. 学生应当了解学校对于药物规范的准则，因为所有的条例都清楚地明文规定用药准则和学生手册中，如有违反，则接受纪律处分。

THE WOODSTOCK ACADEMY HEALTH CENTER RESPONSIBILITES 伍德斯托克学院医务室责任

1. Provide training for appropriate unlicensed personnel on medication administration and review the medication policy. 对没有医疗执照的教职员提供相关的用药训练，并且复习医药规范。
2. See that the prescription medications are kept in a place inaccessible to other students. 确保处方药储存在学生无法自行取得的地方。
3. Keep a record of the administration of medication on a designated log. 在规范日志上记录服药情况和信息。
4. The health office will supply many over-the-counter medications for treatment of common colds, headache/fever, pain, gastrointestinal complaints, etc per standing orders approved by the school Medical Director. These types of medications should not be sent to school with your child because they are not allowed to store it in their dorm rooms and the health office does not have the storage available for medication not being utilized. 根据学校医务主任核准的常规，医务室提供许多非处方药物，可用于治疗感冒，头痛/发烧，疼痛，胃肠道疾病等。 所以请不要让您的孩子携带这些类型的药物到学校。不仅药物不被允许私自存放在宿舍房间里，卫生办公室也没有其他可用于储存这些未经许可，也未使用药物空间。
5. The health office has the authority to deny certain medications/homeopathic/herbal supplements. We do not allow nicotine products on campus. We do not allow protein products for students in the dorm room. Protein products can be stored in the health office, but must also be accompanied by a physician's written authorization. 医务室有权拒绝某些药物/顺势疗法/草药补充剂。 我们绝对不允许在校园内使用任何含有尼古丁成分的产品。 我们也不允许住宿学生使用蛋白质产品。可存储在健康办公室的蛋白质产品，必须附有医生的英文授权书/医嘱。

MEDICATION POLICY ACKNOWLEDGEMENT
医药规范确认书

I have read the parent responsibilities regarding medication and agree to abide by The Woodstock Academy medication policies. 本人已详阅有关药物使用和父母的责任，并同意遵守伍德斯托克学院的医药规范。

Parent Signature: _____ Date: _____
父母签名 日期

I have read the student responsibilities regarding medication and agree to abide by The Woodstock Academy medication policies. 本人已详阅有关药物使用和学生的责任，并同意遵守伍德斯托克学院的医药规范。

Student Signature: _____ Date: _____
学生签名 日期

HEALTH OFFICE HOURS: 医务室时间

The Health Office is open 7:00 AM to 3:30 PM and from 6:00 PM to 8:00 PM Monday-Friday for medication and sick visits. Weekend/holiday hours available based on needs of the students. Phone messages can be left at any time and calls returned as soon as possible. There is on call emergency nursing coverage 24 hours per day, 7 days per week. During off hours, the nurse can be reached by the residential life staff on duty. The duty phone is (860) 207-3490.
医务室于周一至周五上午 7:00 至下午 3:30 及晚上 6:00 至晚上 18:00 用于药物治疗和病假检查。根据学生的需求提供周末/假期时间开放。亦可以随时电话留言，我们的医护人员会在最短的时间内回复电话。 每周 7 天，每天 24 小时随叫随到紧急护理。在非日常工作时间，可以由值班的住宿生活工作人员联系护士。 值班电话是（860）207-3490。

Health Office Contact: Bobbie-Jo Saucier, RN, BSN, ATC
Director of Health Services
57 Academy Road, Woodstock, CT 06281
(860) 928-6575 Option 4
Fax: (860) 928-0313 or (860) 963-6596

SCHOOL PHYSICIAN ：校医看诊时间

We are pleased to announce that Dr. Kristen Xeller has been contracted as The Woodstock Academy Medical Director. The doctor will be coming to the school weekly on Tuesdays/Fridays and as needed for additional appointments. She is also available for telephone consultation 7 days a week as needed. In the event that your child may need to see the physician, they will be asked to contact you for parental permission. The health office will communicate by phone or email after all appointments to update parents on any specific treatments or physician recommendations.

我们很荣幸地聘请 Kristen Xeller 医师为伍德斯托克学院的校医师。 医生于每周二/周五驻校会诊，根据需学生需要进行另外的预约。 若有需要，Xeller 医师也可以进行每周 7 天的电话咨询。 如果您的孩子需要会诊医生时，我学校医务室会要求学生与您联系，以获得家长的许可。 在所有会诊后，医务室会透过电话或电子邮件与你进行沟通，以向父母说明任何特定治疗程序或其医生的建议。

TRANSPORTATION (Health Appointments): 看诊交通事宜

The health services department will arrange transportation to all off campus appointments within a range of 20 minutes from campus. Driving services are available Monday-Friday from 7:00 AM to 5:00 PM. The health services department has established relationships with providers in the surrounding towns of Woodstock, Pomfret, Brooklyn, Putnam, Killingly, and Thompson which include specialties in orthopedics, mental health, podiatry, dermatology, dentistry, orthodontics, walk-in and urgent care centers, Day Kimball Hospital, and laboratory services. If a student/parent requests an appointment with a specific provider or referral outside of our transportation range then the student/parent will be responsible for the cost of transportation for a fee of $30/hour. Transportation services do not include areas of Worcester, Providence, Boston, Norwich, Hartford, etc. This fee will be deducted from your student's account through the business office. The health office

strongly encourages that all routine care and medical appointments are scheduled at home during the summer or school vacation periods. The health office staff is happy to work with students/parents to arrange appointments in this area if medically necessary at the rate mentioned above. 医务室可以安排所有距离学校 20 分钟车程范围内的校外看诊预交通。看诊交通服务时间为周一至周五上午 7:00 至下午 5:00。学校医务室与 Woodstock 周边城镇，其包括 Pomfret、Brooklyn、Putnam、Killingly 和 Thompson 建立相关医疗网络，其中包括当日和紧急护理中心，Day Kimball 医院和实验室，及其科别包括骨科、心理健康、足病、皮肤科、牙科、牙齿矫正等等。如果学生/家长要求在我们范围之外与特定医师进行预约，学生/家长则需负责每小时 30 美元的交通费用。交通服务不包括 Worcester, Providence, Boston, Norwich, Hartford 等地区。其费用会通过学校财务室从学生账户中扣除。医务室强烈建议在暑假或假期期间在家尽速安排所有常规护理和医疗预约。如有必要医务室非常乐意为学生/家长安排当地医疗院所的相关约诊，其费用如上述。

ROUTINE EXAMINATIONS: 例行检查

Routine examinations, i.e. physicals, dental, orthodontics, dermatology, eyes, and gynecological appointments should be made at home with your personal physicians. Please keep in mind your child's school schedule when making these appointments so they can be seen during school breaks. For new concerns or more urgent issues, a list of specialists can be provided at your request. 例行检查其包括与您国内医生的看诊，包括体检，牙科，牙齿矫正，皮肤科，眼科和妇科，请务必以学校行行事历为主做相关日期约诊安排，并记取孩子这些约诊日期，以便在返家期间进行看诊。 对于突发性或紧急的看诊，医务室可根据您的要求提供专科医生列表。

PHARMACY: 药房：

The school utilizes the Stop & Shop Pharmacy in Putnam, CT. The pharmacy has received a copy of all insurance information on file at the school. Every effort is made to utilize your insurance cards. Please keep in mind that not all insurances can be accessed through the pharmacy computer system. Any outstanding amounts are sent to The Woodstock Academy business office and deducted from the student's accounts. 康涅狄格州 Putnam 的 Stop＆Shop 药房为学校特约药店。 药房已收到学校存档的所有保险信息副本。 我们会尽一切努力善用您的保险卡。 请切记，并非所有保险都可以通过药房电脑系统。 任何未付的款项都会寄送到学校，进而从学生账户中扣除。

药房讯息如下：
Stop＆Shop Pharmacy，60 Providence Turnpike，Putnam，CT。06260
电话: (860) 963-2642 传真: (860) 963-2648

Part One

第一部分

The following pages are to be completed by a parent/guardian.

以下部分由家长/监护人填写

MEDICAL EMERGENCY CONSENT 紧急医疗同意书
GENERAL INFORMATION 一般信息
(This form MUST be filled out COMPLETELY)此表务必填写完整

Student's Name 学生中英文全名_____
Last 姓 First名 Middle 中间名

Social Security Number社会安全码 _____-_____-_____ **Date of Birth** 生日_____ **Sex M** ____ **F** ____
月/日/年

Home Address 家庭住址

_____
Number and Street City State Zip

Student resides with 与学生关系: **Both Parents**_____ **Parent 1**_____ **Parent 2**_____ **Other** _____
父母双方 父母一 父母二 其他

Parent 1 full name_____ **Relationship:** _____
父母一中英文全名 与学生关系

#1 Phone ( )_____ **Alternate Phone: ( )** _____
主要联系电话号码 其他联系电话号码

Address if different than student's_____
家庭住址 若与学生的地址不同

Parent 2 full name_____ **Relationship:** _____
父母二中英文全名 与学生关系

#1 Phone ( )_____ **Alternate Phone: ( )** _____
主要联系电话号码 其他联系电话号码

Address if different that student's_____
家庭住址 若与学生的地址不同

Alternate responsible person (not parent) to be reached in case of emergency if parent or guardian is unavailable: 在紧急情况下学校无法与父母或监护人取得联系时，学校可以联系到的替代负责人（非父母）：

Name_____**Phone ( )**_____ _____
中英文全名 联系电话号码

Name of Medical Insurance Company_____ **Phone ( )**_____
医疗保险公司名称 电话号码

Address for insurance company 医疗保险地址

_____

Pre-authorization required? Yes_____ No_____ **Drug Plan? Yes_____ No_____**
是否需要事前取得许可？ 医药处方

Certificate/Policy numbers (include group number if applicable) 医疗保险证号

_____

Name of policy holder_____ **SSN**_____
要保人中英文全名： 社会安全码

Address of policy holder_____
要保人住址

Policy holder's employer: _____ **Policy holder's Date of Birth:** _____
要保人任职单位 要保人生日 月/日/年

**** Please attach copy of both sides of current insurance card ****

Student's known allergies:_____
已知的学生过敏原

Last Tetanus Immunization:_____
学生最近一次施打破伤风疫苗

I hereby give consent for the Director of Health Services, School Nurse, Woodstock Academy Faculty/Staff, or other health care providers considered appropriate by him/her to carry out accepted procedures for diagnosis, immunization, medical, dental, and minor surgical treatment, or counseling for my (son, daughter, ward).If any required immunizations are not completed prior to the student's arrival, I authorize the school to set up needed appointments to properly immunize him/her for what is required and to take full responsibility for any costs incurred in doing so. I also authorize the Health Services Department of Woodstock Academy to share medical information (physical and/or mental health) with employees of Woodstock Academy including, but not limited to, faculty, coaches, dorm parents and administration, for the purpose of coordinating and facilitating the overall well-being of my (son, daughter, ward). This authorization will be in effect for a period of one year. I may revoke this authorization at any time by executing a written revocation addressed to The Woodstock Academy Health Center. I am entitled to a copy of this authorization form and will request one if I desire to have one.
我特此同意医务室主任，学校护士，伍德斯托克学院教职员或其他被认为适当的人员，为我的(儿子/女儿)提供执行诊断，免疫接种，医疗，牙科和小手术治疗的公认程序，或者提供咨询。如果在学生到校之前没有完成必要的免疫接种，我愿授权学校特约医疗院所的预约，以便根据所需对孩子进行适当的免疫接种，并对其负全部责任及其所产生的任何费用。我还授权伍德斯托克学院的医务室与伍德斯托克学院的员工分享医疗信息（身体和/或心理健康），但其中包括但任课教师，体育教练，宿舍管理人员，以协调和促进我的(儿子/女儿)的整体权益。该授权有效期为一年。我可以随时撤销此授权，执行书面撤销给伍德斯托克学院医务室。如果我希望拥有一份此授权表，我有权获得一份副本。

Parent/Guardian Name:_____ **Date:**_____
家长/监护人中英文全名 日期 月/日/年

Signature:_____ **Relationship:**_____
家长/监护人签名 与学生关系

In rare instances, a surgical emergency arises in which written consent by the parent or guardian is legally required. In this event and in order to avoid delay, which might jeopardize the life or recovery of a student, we

request the following permission from the parents or guardian, with the understanding that every effort will be made to contact the parents or guardian in case of any emergency. ***I hereby grant permission to the Director of Health Services, School Nurse or Woodstock Academy Faculty/Staff to give consent for necessary anesthesia and emergency surgical procedures on my (son, daughter, ward).***

在极少数情况下出现的外科紧急情况，其中法律要求父母或监护人书面同意。 在此情况下，为了避免延误医疗，危及学生的生命或康复，我们在此要求父母或监护人给予以下许可。我们将尽一切努力与父母或监护人取得联系。 任何紧急情况我特此授权医务室主任、学校护士或伍德斯托克学院的教职员工，同意我的(儿子/女儿)进行必要的麻醉和紧急外科手术。

Parent/Guardian Name:_____ Date:_____
家长/监护人中英文全名 日期 月/日/年

Signature:_____ Relationship:_____
家长/监护人签名 与学生关系

THE WOODSTOCK ACADEMY – HEALTH SERVICES OFFICE
伍德斯托克学院–医务室

Phone Number: (860) 928-6575 Fax Number: (860) 928-0313 or (860) 963-6596

Please return this completed form with your medical information.

请务必完整填写表格并连同您的医疗信息寄回

We will use this information when calling home regarding your child's health and medication status.

在致电说明您孩子的健康和药物状况时，我们会使用此表格内信息

HIPPA STUDENT HEALTH CALLING INFORMATION

HIPPA 学生健康呼叫信息

Student Name: _____
学生中英文全名

Date of Birth: _____
学生生日 月/日/年

Home Address: _____
学生住址

With whom do you allow us to share your child's personal medical information with at your home? 你若同意将学生的个人医疗讯息和特定人分享，请列出中英文全名，以及与学生的关系

Name: _____ Relationship: _____
中英文全名 与学生的关系

Name: _____ Relationship: _____
中英文全名 与学生的关系

Is there anyone that you do not wish to share it with at your home?
若有哪些人是您不愿意分享学生的医疗信息，请列出中英文全名，以及与学生的关系

Name: _____ Relationship: _____
中英文全名 与学生的关系

Name: _____ Relationship: _____
中英文全名 与学生的关系

How may we contact you? 我们如果与您取得联系？

Home Phone # _____
住家电话

_____ DO NOT leave message 不要在电话留言

_____ Leave brief message, caller name and return #
(Caller's name, phone number, brief message)
简短留言(姓名/回复电话/简短信息)

_____ May leave detailed message 可在电话留具体信息

E-Mail _____
电子邮件

_____ DO NOT leave message 不要在电子邮件留言

_____ Leave brief message 简短电邮留言

_____ Detailed message 可在邮件留下具体信息

Work Phone # _____
公司电话

_____ DO NOT leave message 不要在电话留言

_____ Leave brief message, caller name and return #
(Caller's name, phone number, brief message)
简短留言(姓名/回复电话/简短信息)

Cell Phone # _____
手机电话

_____ DO NOT leave message 不要在电子邮件留言

_____ Leave brief message 简短电邮留言

_____ May leave detailed message 可在电话留具体信息 ____ Detailed message 可在邮件留下具体信息

If student is 18 or over – please discuss / fill out information with them and have them sign. Otherwise, legal guardian must sign. 如果学生年满十八岁，请和学生一起讨论填写表格，让学生自己签名，反之，请合法监护人签名

Signature: _____ Date: _____
签名 日期 月/日/年

Student Name: _____ Date of Birth: _____
学生中英文全名 生日 月/日/年

PERSONAL MEDICAL HISTORY 个人医疗史

To be completed by student's parents/guardians prior to completion of Physician's Physical Examination.
需在医生体检之前由学生的家长/监护人填写。
(Questions, if answered "yes", are to be fully explained in the space provided)
（所有回答"是"的疾病都需在下方空白处做详细解释）

HAS THE STUDENT EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING:
该学生以前或最近有无以下病症：

CHILDHOOD DISEASES 小儿疾病	**YES** 是	**NO** 否		**YES** 是	**NO** 否
Chickenpox 水痘			Rheumatic fever 风湿热		
Measles **麻疹**			Tonsillectomy 扁桃体切除术		
Mumps 腮腺炎			Tonsillitis 扁桃体炎		
Whooping Cough 百日咳			Thyroid disorder 甲状腺疾病		
HISTORY-OTHER 医疗历史--其他			Tuberculosis 结核		
Appendectomy 阑尾切除术			Other lung disease 其它肺病		
Back pain 背痛			Shortness of breath 气短		
Bedwetting 尿床			Chronic cough 慢性咳嗽		
Hernia or Rupture 疝气或破裂			Ulcer-Stomach or Duodenal 胃溃疡或十二指肠		
Malaria 疟疾			Gall Bladder Disorder 胆囊障碍		
Meningitis 脑膜炎			Bone, joint, or other deformities **骨**，**关**节，或其它畸形		
Mononucleosis 单核细胞增多			Recurrent colds/bronchitis 反复感冒/气管炎		
Sinusitis 鼻窦炎			Chest pain and/or pressure 胸痛和/或压力		
Nightmares 噩梦			High or low blood pressure 高或低血压		
Insomnia 失眠			Eye trouble 眼部问题		
Anemia or other blood disease 贫血或其他血液病			Dental or Gum Problems 牙齿或牙龈问题		
Arthritis 关节炎			Stomach or intestinal trouble 胃肠问题		
Asthma, hay fever 哮喘，花粉症			Weight loss or gain 体重减轻或增加		
Cancer 癌症			Eating disorder 饮食失调		
Tumor 肿瘤			Frequent anxiety 经常的焦虑症		
Colitis 结肠炎			Depression 抑郁症		
Strep Throat 咽喉炎			Tobacco use 吸烟		
Concussion or unconsciousness 脑震荡或无意识			History of drug use 毒品使用		
Other head injury 其他头部创伤			Alcohol use 酒精试用历史		
Diabetes 糖尿病			ADD 注意缺陷障碍		
Eczema or other skin disease 湿疹或其他皮肤病			ADHD 多动症		
Epilepsy 癫痫			Other 其他:		
Headaches or migraines 头痛或偏头痛			FEMALES ONLY: 女性学生需填写:		

Hearing difficulty 听力障碍			History of pregnancy 怀孕历史		
Otitis media/Ear Infections 中耳炎/耳部感染			Severe cramps 严重经痛		
Heart murmur/palpitations 心脏杂音/心悸			Irregular periods 经期不调		
Heart disease 心脏病			Use of birth control 节育措施		
Hepatitis 肝炎			Excessive menstrual flow 月经量过大		
Liver disease 肝病			Frequent yeast infections 频繁的酵母菌感染		
Jaundice 黄疸			Other 其他:		
Kidney disease 肾病					
Frequent Urinary Tract Infections 频繁的尿路感染					
Other 其他:					

FAMILY HISTORY-Have any of your relatives ever had any of the following? 家族历史--您的亲戚中是否有人有以下病症**?**	**YES** 是	**NO** 否
Tuberculosis 结核		
Diabetes 糖尿病		
Kidney Disease 肾病		
Heart Disease 心脏病		
Epilepsy, Convulsions 癫痫，抽搐		
Asthma 哮喘		
Stomach Disease 胃病		
Cancer 癌症		
Mental Health Issues 心理疾病		
Have you had any orthopedic injuries to the extremities or back to include, but not limited to fractures, sprain/strains, tendonitis, dislocation, bursitis, surgeries, and cartilage problems. (If yes, please use this area below to describe any situations in detail marked above. Also, provide the health center with a copy of any pertinent medical findings, i.e. physical limits placed on student's ability to do sports. 你在四肢和背部是否有过骨科损伤， 包括骨折，扭伤/损伤，肌腱炎，关节脱位，滑囊炎，手术和软骨等问题。（如果有，请在以下空白处解释具体情况。并请向医务室提供相关医疗证明，若医生建议该学生限制做若干体育运动项目的证明等。）	**YES** 是	**NO** 否

Have you had any illness, injury, or been hospitalized for anything other than previously noted? 你有任何除上述问题以外的疾病、受伤或住院史吗？	YES 是	NO 否

Have you received psychiatric treatment or counseling for a personality or character disorder, drug/alcohol abuse, eating disorder, or an emotional problem? 你有接受过精神病治疗、性格紊乱疾病咨询，滥用毒品/酒精，饮食疾病或情绪问题的治疗吗？	YES 是	NO 否

Has your child had any psychological testing (LD, ADHD, Neuropsych, projective)? If yes, please provide a copy of testing to the health center. 您的孩子曾接受过任何心理测试吗？（学习障碍，多动症等神经精神方面疾病）》如果有，请向医务室提交检测证明。	**YES** 是	**NO** 否

Recent change in the health status of family member (s)? 最近家庭成员中有健康状况的变化吗？	**YES** 是	**NO** 否

If you have answered yes to any of the above questions please use the remaining space provided for comments and additional information.如果你对上述任何问题回答了“是”，请在以下空白处作解释并提供额外信息。

Student Signature: _____ Date: _____
学生签名（中英文） 日期 月/日/年

Parent/Guardian Signature: _____ Date: _____
家长/监护人签名 日期 月/日/年

MEDICATION AUTHORIZATION FORM

Must be completed for <u>all students</u>.

药物治疗授权书 (所有学生务必填写)

学生中英文姓名 Student Name:_____ _____ 日期 Date: _____
月/日/年

家长/监护人 Parent / Guardian Name:_____

1) I have reviewed the enclosed **Woodstock Academy Medication Policy** and give permission to the school nurse or designee to administer prescription medication as ordered by my son/daughter's physician or The Woodstock Academy's physician. 我已经详阅随附的伍德斯托克学院医药规范，并允许学校护士或指定人员依照我儿子/女儿的医生或伍德斯托克学院校医要求管理处方药。

家长签名 Parent Signature：_____ (必要)

2) I give permission for my son / daughter to have a one day supply of medication on his / her person (this is for sports and other off campus events). 我允许我的儿子/女儿自带一天剂量的药物(这是为了体育外出比赛或其他需要离校的活动)。

家长签名 Parent Signature：_____ (必要)

3)I give permission to the school nurse or designee to administer over the counter medication to my son/daughter as prescribed in the Standing Orders from The Woodstock Academy physician. 我允许学校护士以及被指派者管理和发放由学校指定医生发放给我孩子的药物。
家长签名 Parent Signature：_____ (必要 或请备注说明)

4) I give permission for my son / daughter to carry his / her emergency medication on his/her person. __Emergency Inhaler__/__ Epi Pen__/_____ (other medication). 我允许我的儿子/女儿在他/她的人身上携带他/她的紧急药物。 紧急吸入器 / Epipen /_____（其他药物）

家长签名 Parent Signature：_____ (必要)

5) I give permission for my son / daughter to travel home with all of his/her medications at the end of the school year. 在学年结束时，我允许我的儿子/女儿带着他/她的所有药物回家。
家长签名 Parent Signature：_____ (必要)

(Parent will notify health office in writing of where to mail medication if permission not granted.)
（如果未获得许可，家长必须书面通知医务室邮寄药物的地址。）

I have read the **Woodstock Academy Medication Policy** in its entirety and agree to abide by its content.
我已详阅伍德斯托克学院医药规范，并遵守其内容。

家长签名 Parent Signature：_____ (必要)

I have read the **student responsibilities** regarding medication and agree to abide by its contents.
我已详阅伍德斯托克学院学生责任，并遵守其内容。

学生签名 Student Signature：_____ (必要)

INFLUENZA VACCINE CONSENT AND ADMINSTRATION RECORD

流感疫苗同意书以及注射记录

The Flu vaccine is OPTIONAL, but STRONGLY recommended.
流感疫苗接种为自愿性但学校强烈建议注射。
The Vaccine is NOT Available after November 1st, or when supply runs outs. Flu vaccines will be administered as soon as they become available this Fall. There will be a charge applied to the student's account to cover the cost of the vaccine. 在十一月一日以后或流行性感冒疫苗供应不足时，不提供注射。流行性感冒疫苗会在一开学时开始施打。学校会从学生账户支付疫苗接种的费用。

Please read the Vaccine Information Statement Sheets: 请详细阅读所附下面链接的有关流感疫苗信息：
https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

I have read the accompanying Vaccine Information Statement, and have had a chance to ask questions. I understand the benefits and risks of vaccination and request that the vaccine be given to me or the person named below for whom I am authorized to sign. 我已详阅所付的疫苗接种信息文件，并且已有机会询问。我了解疫苗的好处及风险，并授权给本人或者以下签名的人接种此疫苗。

Student Nam _____ (Please Print 请工整填写) Date (日期) _____
(学生中英文姓名) 月/日/年

Signature of Parent/Guardian _____ Relationship (与学生关系) _____
(家长/监护人签字)

☐ I have read the accompanying Vaccine Information Statement. I request that the vaccination be given to my son/daughter for whom I am authorized to sign. 我已详阅所付的疫苗接种信息文件。我授权给我的儿子/女儿接种疫苗。

☐ I decline the influenza vaccination for my son/daughter for whom I am authorized to sign.
我拒绝授权并签署让我的儿子/女儿进行流感疫苗接种。

FOR CLINIC/OFFICE USE
校医使用栏

Clinic Name: The Woodstock Academy Health Office

Clinic Address: 57 Academy Rd. Woodstock, CT 06281

Date: _____ Allergies: _____

Temp: _____ Site of Injection: _____

Vaccine Manufacturer: _____ Lot #: _____ Exp.: _____

Signature of Vaccine Administrator: _____ Title: _____

RESIDENTIAL STUDENT INJURY & SICKNESS PLANS: 2020-2021
住宿生伤病计划: 2020-2021

Dear Parent/Guardian:
亲爱的家长/监护人：

Out of concern for the health and welfare of all our students, the Woodstock Academy requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by local providers and practitioners. 出于对所有学生的健康和福利的关注，伍德斯托克学院要求每个学生都有一个全面的伤病计划，这个计划不仅可以满足医疗服务的高成本，并且被当地的医疗提供者和从业者所接受。

- **Please note that our health center will not accept medical insurance policies issued in a foreign country or from a company outside the United States. 请注意，我们医务室不接受任何外国或美国境外公司所签发的医疗保险。**

To help you meet your financial responsibilities we offer the following comprehensive plan:
为帮助您履行相关的医疗财务责任，我们提供以下综合保险计划：

PREMIER HEALTH PLAN I (PRIMARY COVERAGE)

This plan provides primary, first dollar benefits for those of you who do not have any insurance or whose coverage is not accepted outside your geographical area. This plan will cover students anywhere in the world, except your home country, for a 10 month period for a premium of ***$2,000***. This plan was designed especially for private secondary schools and meets the mandated requirements of state laws in Connecticut. 该计划为那些没有任何保险或未在您所在地区以外接受保险的人提供初级，第一美元福利。 该计划将涵盖世界上任何地方的学生，除了您的国家以外，为期 10 个月，保费为 2,000 美元。 该计划专为私立中学设计，符合康涅狄格州州法律的强制要求。

RESIDENTIAL STUDENTS WHO DO NOT HAVE COVERAGE WITH A USA BASED COMPANY (AS A DEPENDENT ON THEIR PARENT'S PLAN) MUST ENROLL.
但凡没有美国境内保险公司保险的学生，一律参加

You must select one of the options provided below. Please note that this document is an addendum to your Enrollment Agreement and both your Agreement and this Addendum must be returned together to the school. The basic provisions and exclusions of this plan are outlined in the summary attached. Certificates with further details will be issued to every participant along with a personal identification card. Please check the appropriate boxes below, include student's name, sign your name, date and return promptly to Bobbie-Jo Saucier by email at bsaucier@woodstockacademy.org or by mail to: The Woodstock Academy, 57 Academy Road, Woodstock, CT. 06281. Thank you. 您必须选择以下提供的选项之一。 请注意，本文件是您的注册协议的附录，您的协议必须和本附录必一起交回给学校。 附件摘要概述了该计划的基本规定和个别例外事项。 将向每位参与者发放带有更多详细信息的证书以及个人身份证。 请检查下面相应的方框，包括学生姓名，签名，日期，您可以及时通过电子邮件 bsaucier@woodstockacademy.org 或邮寄至学校地址：Woodstock Academy，57 Wood Road，Woodstock，CT，06281 给学校务室主任 Bobbie-Jo Saucier。谢谢。

2020-2021 STUDENT INJURY & SICKNESS PLANS

2020-2021 学生伤病计划

1. [ ] Enroll _____ in plan for**:**
参加 **STUDENT NAME** 学生中英文姓名 此项计划

[ ] A 10 month plan August 21st-June 20st ***($2,000)***
从八月二十一日至隔年六月二十日 为期十个月（两千美元）

3. [ ] Do not enroll _____ in the plan**.** In making
不参加 **STUDENT NAME** 学生中英文姓名 此项计划

this selection, I accept full responsibility for all medical costs incurred by my child. My present in-force plan is as follows: (Please include a copy of the front and back of your insurance card) 勾选此选项同时，我对我孩子承担的所有医疗费用和全部责任。 我现有的有效保险范围涵盖如下: (请附上保险卡正面和背面的副本）

_____

_____

_____

_____

INSURANCE COMPANY NAME
保险公司名称

POLICY NUMBER & PHONE NUMBER
保险证号/电话号码

INSURANCE COMPANY ADDRESS
保险公司地址

CITY, STATE AND ZIP CODE
城市/ 州别/ 邮编

SIGNATURE OF PARENT/GUARDIAN
家长/监护人签名

DATE
日期
月/日/年

Part Two

第二部分

The following pages are to be completed by a physician.
以下部分由医生填写

学生中英文姓名 Name of Student _____ 生日 Date of Birth _____

过敏 Allergies _____ 检查日期 Date of Exam _____

身高 Height _____ 体重 Weight _____

血压 B/P _____ 呼吸 Respirations _____ 脉搏 Pulse _____

Skin 皮肤		Tonsils 扁桃体		Thyroid 甲状腺		Kidneys 肾	
Hair 头发		Teeth 牙齿		Breast 胸		Hernia 疝气	
Nails 指甲		Gums 牙龈		Lungs/Thorax 肺/胸腔		Genitalia 生殖器	
Eyes 眼睛		Mouth 口腔		Heart 心脏		Rectum 直肠	
Vision 视力	R 右 20/ L 左 20/	Tongue 舌头		Abdomen 腹部		Back/Spine 背部/脊柱	
Ears 耳朵		Nose 鼻子		Liver 肝		Extremities 四肢	
Hearing 听力		Nodes 淋巴		Spleen 脾		**HGB/HCT**:**	

Remarks on Abnormalities 异常处请备注:

_____

Neurological and Psychiatric (hospitalization, outpatient treatment, therapy)
神经及精神病史(住院史及门诊治疗史):

_____

Any Chronic Illnesses 任何慢性疾病: ***If student has asthma, please record personal best peak flow and include full asthma plan***
*如果曾患哮喘，请记录治疗历史和用药。

_____

Any restrictions from activities (must include duration of restriction) 不能进行体育运动的限制（限制运动周期）?

_____

Medications (Physician's Request for Medication Administration needs to be completed by the prescribing doctor in English) 药物（如果该学生的医师需要学校药物部门开处方药，务必请医师以英文填写药物申请）

_____

_____

_____

Student is at High Risk for TB due to geographic location or exposure Y / N
学生是否由于所住地区有患肺结核的高风险? 是/否
(See additional form for tuberculosis screening). 请参阅结核病筛查的其他表格

IMMUNIZATION HISTORY 免疫接种历史							
(百白破和小儿麻痹)最后一针必须在 4 周岁之前接种 *Last dose must be given on or after 4th birthday (Polio and DTP)	**PRIMARY IMMUNIZATION SERIES** 主要接种的疫苗					**OTHER IMMUNIZATIONS** 其他疫苗	
	1ST DOSE MO/DAY/YR 第一剂 月/日/年	2ED DOSE MO/DAY/YR 第二剂 月/日/年	3RD DOSE MO/DAY/YR 第三剂 月/日/年	4TH DOSE MO/DAY/YR 第四剂 月/日/年	5TH DOSE MO/DAY/YR 第五剂 月/日/年	DATE 日期	VACCINE 疫苗
Vaccine Type 疫苗种类							
DTP (4) 百白破(4 剂)							
Tdap (1) 百白破疫苗(补强剂)(1 剂)							
POLIO（3） 小儿麻痹（3 剂）							
MEASLES（2） 麻疹(2 剂)							
MUMPS(2)腮腺炎(2 剂)							
RUBELLA(2) 风疹(2 剂)							
MMR(2)麻风腮(2 剂)							

HBV(3)乙肝(3 剂)							
MENINGOCOCCAL 流脑疫苗							
VARICELLA Date of 2 vaccines 水痘 （请注明 2 剂的注射日期）		/ /	/ /	Date of disease (曾感染水痘日期)	/ /	DATE 日期	RESULTS 结果
MANTOUX TESTING REQUIRED FOR ALL HIGH RISH 1st YEAR STUDENTS PPD 结核菌测试对于第一年的新生都要求测试						/ /	

Examiner's Name Typed or Printed: _____ Telephone: _____
称检验医师全名 电话号码

Address: _____ Fax: _____
称检地址 传真

Signature: _____ Date: _____
称检验医师签名 日期 月/日/年

Students Name: _____ Date of Birth: _____
学生中英文全名 生日 月/日/年

CARDIOVASCULAR HISTORY
心血管疾病史

1) Prior occurrence of exertional chest pain/discomfort or syncope/near syncope as well as excessive, unexpected, and unexplained shortness of breath or fatigue associated with exercise?
过去曾有任何胸部疼痛、不适，或发生过昏厥、近似昏厥,或曾有过任何突然的、原因不明的,因运动而引起的极度呼吸短促或疲乏吗？

Yes 是____ No 否____ If yes, please explain 如果选是，请备注原因: _____

2) Past detection of a heart murmur or increased blood pressure? 过去曾有心杂音或者高血压病史吗？

Yes 是____ No 否____ If yes, please explain 如果选是，请备注原因: _____

3) Family history of premature death (sudden or otherwise), or significant disability from cardiovascular disease in close relative (s) younger than 50 years old, or specific knowledge of the occurrence of certain conditions (e.g. hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan's syndrome, or clinically important arrhythmias)? 家庭病史中，曾有过早夭(突然的或其他原因),或者 50 岁以下的近亲中曾有过因为心血管疾病导致严重残疾的,或曾有过任何值得关注的心血管疾病的病史吗(比如心肌症，扩大型心肌症，或者严重心律失常)？

Yes 是____ No 否____ If yes, please explain 如果选是，请备注原因: _____

CARDIOVASCULAR ASSESSMENT/TESTING
心血管监测

1) Auscultation to identify heart murmurs, especially any murmur suggestive of dynamic left ventricular outflow obstruction: 听诊心杂音，尤其注意任何可能暗示左心室血液外流障碍的杂音
Sitting 坐姿_____ Standing 站姿_____

2) Evaluation of femoral artery pulses to exclude coarctation of the aorta:
检查股动脉来排除大动脉收缩的可能性

Left 左_____ Right 右 _____

3) Identification of any physical signs of Marfan's syndrome?
检查是否有任何显示马凡氏综合征的症状？

Yes 是_____ No 否 _____

4) If indicated 若有显示:
EKG results 心电图结果: _____ Echocardiogram results 超声心动图结果: _____

Other 其他: _____

This student may:

- ☐ Participate fully in the school program including athletic activities and competitive sports.
  可以完全参与学校活动，包括体育活动和竞技体育。
- ☐ Participate in the school program including athletic activities and competitive sports with the following restrictions/adapation: 通过下述限制/调整参加学校计划，包括体育活动和竞技体育：

Oral Health Assessment
口腔健康评估

Dental Examination Completed by: 完成口腔检查：

☐ Dentist 牙医 Date 日期: _____ 月/日/年

Dental Screening Completed by: 牙科筛查完

- ☐ MD/DO
- ☐ APRN
- ☐ PA
- ☐ Dental Hygienist 牙科卫生师
  - ☐ Screening Normal 筛检正常

- ☐ Screening Abnormal (Describe)筛检异常 (请叙述)

  _____

Referral Made: 是否因主医生建议转诊至牙医师看诊

- ☐ Yes 是
- ☐ No 否

Risk Assessment:

- ☐ Low
- ☐ Moderate
- ☐ High

Describe risk factors identified 请叙述已识别的风险因素: _____

Recommendation(s) by health care provider: 医疗保健提供者的建议：

_____

Examiner's Name Typed or Printed: _____ Telephone: _____
检验医师全名 电话号码

Address: _____ Fax: _____
检验地址 传真

Signature: _____ Date: _____
检验医师签名 日期 月/日/年

PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION

处方药物管理规范

Student name _____ Date of Birth_____
学生中英文全名 生日 月/日/年

Physician's name _____
医师中英文全名

Phone _____ Fax _____
电话 传真

Diagnosis_____ Date of Diagnosis: _____
诊断 诊断日期 月/日/年

Allergies: _____
过敏药物

Student must receive adequate instruction from their prescribing physicians regarding the administration, desired effect, and side effects of all medication. Order should include drug name, dose, route, time of administration, and frequency. 学生须接受处方医生关于所有药物的给药，所需效果和副作用的充分指导。 订单应包括药物名称，剂量，途径，给药时间和频率。

MEDICATION 1 药物一

_____

Everyday _____ Academics Only_____ This medication is optional/PRN: _____
每日 上学期间 此药物为非必要

MEDICATION 2 药物二

_____

Everyday _____ Academics Only_____ This medication is optional/PRN: _____
每日 上学期间 此药物为非必要

MEDICATION 3 药物三

_____

Everyday _____ Academics Only_____ This medication is optional/PRN: _____
每日 上学期间 此药物为非必要

I hereby request that the above ordered medication be administered by school personnel.
我在此要求学校订购上述的药物并由学校人员管理。

Physician's signature_____ Date_____
医师签名 日期 月/日/年

TUBERCULOSIS SCREENING

肺结核检查

Mandatory for all 1st year Woodstock Academy students.

所有第一年注册的新生都必须检查

All screenings must be performed within 3 months of admission to The Woodstock Academy.

所有的检查并需在入学前 3 个月完成。

Complete documentation must be received PRIOR to travel to The Woodstock Academy.

所有完成的检查报告必须在入学前寄送给伍德斯托克学院。

中英文姓名 Student Name:_____ 生日 Date of Birth: _____

皮试日期 Date of PPD(Mantoux) Plant: _____ 医生签名 Initial of Provider:_____

测试结果读取日期 Date of Reading: _____ 医生签名 Initial of Provider:_____

结果（毫米）Result (Read in millimeters): _____ 医生签名 Initial of Provider:_____

A Chest X-ray must be performed on all students with positive PPD Screening. Results must accompany this form. 如果测试结果是阳性，那么学生必须要拍摄胸腔 X 光片。

If PPD is read as 10mm or greater, prophylactic treatment for Latent Tuberculosis must be considered. If parent or student over the age of 18 declined prophylactic treatment, we must receive a signed and dated document stating that they were informed of the risks of tuberculosis, the benefits of treatment, and their decision to decline from said treatment. 如果肺结核皮试结果大于 10 毫米，必须采取对于潜伏性结核病的预防治疗。如果家长/监护人或者年满 18 岁的学生不愿意采取肺结核治疗，必须写明已知肺结核的危害、治疗用处，并决定不采取相关治疗。

If other testing such as QuantiFERON Gold has been performed, please attach results to this form.
如果有其他测试，例如 QuantiFERON Gold ， 请将结果随表附上。

医生签名 Signature of Physician/ Provider:_____

医院/诊所地址 Address of Physician:_____

_____

电话号码 Phone number/邮件地址 Email Address:

_____