THE WOODSTOCK ACADEMY HEALTH SERVICES

MANDATORY HEALTH DOCUMENTATION GUIDELINES

Dear Parent / Guardian,

Please note that all health office paperwork MUST be completed and mailed, faxed, or emailed to the health office by **July 31, 2023** prior to registration at The Woodstock Academy.

Emergency Medical Consent – Please write names and addresses in English and be sure to sign both areas at the bottom of the form.

Insurance- All 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.

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 2023 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.

*Be sure that your child's name, date of birth and any allergies are clearly written at the top of the physical form.

Immunizations – All immunizations must be completed and up to date as follows:

- **Covid 19 Vaccine-** Students are required to have received the primary Covid-19 series **or** one dose of bivalent vaccine prior to arrival to campus. If student is not vaccinated prior to arrival, vaccine will be arranged locally.
- **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.
- **Tdap** (Tetanus / Pertussis) 1 single dose between the ages of 11-18.
- **Polio** – At least 3 doses (the last one given on or after the 4th birthday).
- **MMR** – (Mumps, Measles, Rubella) 2 Doses separated by at least 28 days (1st dose on or after the 1st birthday).
- **Hepatitis A**- 2 doses given 6 months apart starting on or after 1st birthday (Required for students born 1/1/07 or later).
- **Hepatitis B** – 3 doses (completed within a 6 month period).
- **Varicella (chicken pox)** – Verification of disease (confirmed in writing by Dr.) or
  - 2 doses separated by at least 4 weeks for any unvaccinated student, or
  - 2 doses separated by 3 months on or after the 1st birthday.
- **Meningococcal Vaccine** – At least 1 for all boarding students before entry into high school.

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.

As required by law and to protect your child's health, our Woodstock Academy Medical Director will share immunization information with the State of CT Department of Public Health for any student that is required to be vaccinated once on campus.

Personal Medical History – Must be completed and signed each year.

Student Health Calling Information Form-Must be completed and signed each year.

Medication Authorization Form – Must be completed and signed each year.

Physicians Request for Medication Administration Form-No medication, vitamins, or supplements will be administered without a doctor's written order.

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).

57 Academy Rd. Woodstock, CT 06281 Phone: 860-928-6575, Fax: 860-928-0313, Email: nurses@woodstockacademy.org

THE WOODSTOCK ACADEMY MEDICATION POLICY

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:

1. Student will be evaluated by his/her prescribing physician at least once annually.
2. Medication must be sent directly to the Health Center in the original container, clearly labeled with the name of the student and medication on it. The Health Center will not accept improperly labeled containers.
3. All students are to receive adequate instruction from the prescribing physician regarding the self-administration, desired effect, and side effects of all medications.
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.
5. A Medication Authorization form must be completed and signed by the parent(s) and student.
6. **No medication or supplements are allowed in student rooms without Health Center authorization.**

NON-COMPLIANCE WITH MEDICATIONS

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.

PARENT/GUARDIAN RESPONSIBILITIES REGARDING MEDICATION:

1. The parent is responsible for obtaining all paperwork needed by the physician's office with respect to medications and other supplement/vitamin needs.
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).
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 winter and spring breaks unless they have been filled at our local pharmacy.**
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.
5. All medications, supplements, vitamins, and herbal medication administered at school must be labeled in English.

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.
7. Parents are aware that any medication not picked up in the health office 2 weeks following school closing will be destroyed.

STUDENT RESPONSIBILITIES REGARDING MEDICATION:

1. The student is to come to the Health Center for all prescribed medications at the proper times.
2. The student is to alert the Health Center immediately if there are any questions or concerns with regard to their medication.
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.
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.**
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.

ACADEMY HEALTH CENTER RESPONSIBILITIES:

1. Provide training for appropriate unlicensed personnel on medication administration and review the medication policy.
2. See that the prescription medication is kept in a place inaccessible to other students.
3. Keep a record of the administration of medication on a designated log.
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.
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.

MEDICATION POLICY ACKNOWLEDGEMENT

I have read the parent/student responsibilities regarding medication and agree to abide by The Woodstock Academy medication policies.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

HEALTH OFFICE HOURS:

The Health Office is open 7:00 AM to 11:00 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.

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
Email: bsaucier@woodstockacademy.org

SCHOOL PHYSICIAN :

We are pleased to announce that Dr. Kristen Xeller has been contracted as The Woodstock Academy physician for the 2023/2024 school year. The doctor will be coming to the school twice weekly 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.

TRANSPORTATION (Health Appointments):

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.

ROUTINE EXAMINATIONS:

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.

PHARMACY:

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.

Stop & Shop Pharmacy, 60 Providence Turnpike, Putnam, CT. 06260
Phone: (860) 963-2642 Fax: (860) 963-2648

Part One

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

MEDICAL EMERGENCY CONSENT
GENERAL INFORMATION
(This form MUST be filled out COMPLETELY)

Student's Name_____
Last First Middle

Date of Birth_____**Sex** _____

Home Address_____
Number and Street City State Zip

Student resides with: Both Parents_____**Parent 1**_____**Parent 2**_____ **Other** _____

Parent 1 full name_____ **Relationship:** _____

#1 Phone ( )_____ **Alternate Phone: ( )** _____

Address if different than student's_____

Parent 2 full name_____ **Relationship:** _____

#1 Phone ( )_____ **Alternate Phone: ( )** _____

Address if different that student's_____

Alternate responsible person (not parent) to be reached in case of emergency if parent or guardian is unavailable:

Name_____**Phone ( )**_____

Name of Medical Insurance Company_____ **Phone ( )**_____

Address for insurance company _____

Pre-authorization required? Yes____ **No**____ **Drug Plan? Yes**____ **No**____

Certificate/Policy numbers (include group number if applicable)_____

Name of policy holder_____ **SSN**_____

Address of policy holder_____

Policy holder's employer: _____ **Policy holder's Date of Birth:** _____

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

Student's known allergies:_____

Last Tetanus Immunization:_____

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 (including Covid 19 vaccine), 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 authorize WA Medical Director to share my child's immunization information with the State of CT Department of Public Health. 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.

Parent/Guardian Name:_____**Date:**_____

Signature:_____**Relationship:**_____

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).*

Parent/Guardian Name:_____**Date:**_____

Signature:_____**Relationship:**_____

THE WOODSTOCK ACADEMY – HEALTH SERVICES OFFICE
Phone Number: (860) 928-6575 Fax Number: (860) 928-0313 or (860) 963-6596
Email: nurses@woodstockacademy.org
We will use this information when calling home regarding your child's health and medication status.

THE WOODSTOCK ACADEMY HEALTH SERVICES

HIPPA STUDENT HEALTH CALLING INFORMATION

Student Name: _____
Date of Birth: _____
Home Address: _____

With whom do you allow us to share your child's personal medical information with at your home?
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Is there anyone that you do not wish to share it with at your home?
Name: _____ Relationship: _____
Name: _____ Relationship: _____

How may we contact you?

Home Phone # _____ E-Mail _____

_____ DO NOT leave message
_____ Leave brief message, caller name and return #
(Caller's name, phone number, brief message)
_____ May leave detailed message

_____ DO NOT leave message
_____ Leave brief message
_____ Detailed message

Work Phone # _____

_____ DO NOT leave message
_____ Leave brief message
_____ May leave detailed message

Cell Phone # _____

_____ DO NOT leave message
_____ Leave brief message
_____ Detailed message

If student is 18 or over – please discuss / fill out information with them and have them sign. Otherwise, legal guardian must sign.

Signature: _____ Date: _____

Student Name: _____ Date of Birth: _____

PERSONAL MEDICAL HISTORY

THE WOODSTOCK ACADEMY HEALTH SERVICES

To be completed by student's parents/guardians prior to completion of Physician's Examination.
(Questions, if answered "yes", are to be fully explained in the space provided)

HAS THE STUDENT EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLO WING:

CHILDHOOD DISEASE	YES	NO		YES	NO
Chickenpox			Rheumatic fever		
Measles			Tonsillectomy		
Mumps			Tonsillitis		
Whooping Cough			Thyroid disorder		
HISTORY-OTHER			Tuberculosis		
Appendectomy			Other lung disease		
Back pain			Shortness of breath		
Bedwetting			Chronic cough		
Hernia or Rupture			Ulcer-Stomach or Duodenal		
Malaria			Gall Bladder Disorder		
Meningitis			Bone, joint, or other deformities		
Mononucleosis			Recurrent colds/bronchitis		
Sinusitis			Chest pain and/or pressure		
Nightmares			High or low blood pressure		
Insomnia			Eye trouble		
Anemia or other blood disease			Dental or Gum Problems		
Arthritis			Stomach or intestinal trouble		
Asthma, hay fever			Weight loss or gain		
Cancer			Eating disorder		
Tumor			Frequent anxiety		
Colitis			Depression		
Strep Throat			Tobacco use		
Concussion or unconsciousness			History of drug use		
Other head injury			Alcohol use		
Diabetes			ADD		
Eczema or other skin disease			ADHD		
Epilepsy			Other:		
Headaches or migraines			**FEMALES ONLY:**		
Hearing difficulty			History of pregnancy		
Otitis media/Ear Infections			Severe cramps		
Heart murmur/palpitations			Irregular periods		
Heart disease			Use of birth control		
Hepatitis			Excessive menstrual flow		
Liver disease			Frequent yeast infections		
Jaundice			Other:		
Kidney disease					
Frequent Urinary Tract Infections					
Covid- 19					

FAMILY HISTORY- Have any of your relatives ever had any of the following?	YES	NO

Tuberculosis		
Diabetes		
Kidney Disease		
Heart Disease		
Epilepsy, Convulsions		
Asthma		
Stomach Disease		
Cancer		
Mental Health Issues		
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.	YES	NO

Have you had any illness, injury, or been hospitalized for anything other than previously noted?	YES	NO

Have you received mental health services in the past or currently? If yes, please explain in detail reason for services and treatment.	YES	NO

Has your child had any psychological testing (LD, ADHD, Neuropsych, projective)? If yes, please provide a copy of testing to the health center.	YES	NO

Recent change in the health status of family member (s)?	YES	NO

If you have answered yes to any of the above questions please use the remaining space provided for comments and additional information.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

THE WOODSTOCK ACADEMY HEALTH SERVICES

MEDICATION AUTHORIZATION FORM

Must be completed for all students.

Student Name: _____ Date: _____

Parent/Guardian Name: _____

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.

Parent Signature: _____ (REQUIRED)

I give permission for my son / daughter to have a **one** day supply of medication on his/her person with the exception of controlled substances. (This is for sports and other off campus events).

Parent Signature: _____

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.

Parent Signature: _____ (REQUIRED or Explain)

I give permission for my son / daughter to carry his / her emergency medication on his/her person. ___Emergency Inhaler___/___Epi Pen___/_____ (other medication)

Parent Signature: _____

I give permission for my son / daughter to travel home with all of his/her medications at the end of the school year.

Parent Signature: _____

(Parent will notify health office in writing of where to mail medication if permission not granted.)

I have read the **Woodstock Academy Medication Policy** in its entirety and agree to abide by its content.

Parent Signature: _____ (REQUIRED)

I have read the **student responsibilities** regarding medication and agree to abide by its contents.

Student Signature: _____ (REQUIRED)

THE WOODSTOCK ACADEMY HEALTH SERVICES

INFLUENZA VACCINE CONSENT AND ADMINSTRATION RECORD

The Flu vaccine is OPTIONAL, but strongly recommended.

The Vaccine is NOT Available after November 1st, or when supply runs outs.

Flu vaccines will be administered in late September/October (pending supply arrival). There will be a charge applied to the student's account to cover the cost of the vaccine.

Please read the attached Vaccine Information Statement Sheets

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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.

Student Name (Please Print): _____Date: _____

Signature of Parent/Guardian: _____Relationship: _____

o 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.

FOR CLINIC/OFFICE USE

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: _____

THE WOODSTOCK ACADEMY HEALTH SERVICES

RESIDENTIAL STUDENT INJURY & SICKNESS PLANS: 2023-2024

Dear Parent/Guardian:

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.

- **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.**

To help you meet your financial responsibilities we offer the following comprehensive plan:

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 ***$2,300***. This plan was designed especially for private secondary schools and meets the mandated requirements of state laws in Connecticut.

RESIDENTIAL STUDENTS WHO DO NOT HAVE COVERAGE WITH A USA BASED COMPANY (AS A DEPENDENT ON THEIR PARENT'S PLAN) MUST ENROLL.

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 our health office by email at nurses@woodstockacademy.org or by mail to: The Woodstock Academy, 57 Academy Road, Woodstock, CT. 06281.

2023-2024 STUDENT INJURY & SICKNESS PLANS

1. [ ] Enroll _____ in plan for**:**
STUDENT NAME

[ ] A 10 month plan August 19, 2023-June 18, 2024 ***($2,300)***

3. [ ] Do not enroll _____ in the plan**.** In making
STUDENT NAME

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)

INSURANCE COMPANY NAME **POLICY NUMBER & PHONE NUMBER**

_____ **INSURANCE**
COMPANY ADDRESS **CITY, STATE AND ZIP CODE**

SIGNATURE OF PARENT/GUARDIAN **DATE**

Part Two

The following pages are to be completed by a physician.

THE WOODSTOCK ACADEMY HEALTH SERVICES

Name of Student_____ Date of Birth_____

Allergies_____Date of Exam

_____

Height Weight B/P Respirations Pulse_____

Skin		Tonsils		Thyroid		Kidneys	
Hair		Teeth		Breast		Hernia	
Nails		Gums		Lungs/Thorax		Genitalia	
Eyes		Mouth		Heart		Rectum	
Vision	R 20/ L 20/	Tongue		Abdomen		Back/Spine	
Ears		Nose		Liver		Extremities	
Hearing		Nodes		Spleen		HGB/HCT**:	

Remarks on Abnormalities:

_____

Neurological and Psychiatric (hospitalization, outpatient treatment, therapy):

_____

_____

Any Chronic Illnesses: *If student has asthma, please record personal best peak flow and include full asthma plan*

_____

_____

Any restrictions from activities (must include duration of restriction)?

_____

_____

Medications (Physician's Request for Medication Administration needs to be completed by the prescribing doctor)

_____

Student is at High Risk for TB due to geographic location or exposure Y / N (See additional form for tuberculosis screening).

Students Name: _____ Date of Birth: _____

IMMUNIZATION HISTORY							
Vaccines	PRIMARY IMMUNIZATION SERIES					Other Immunizations	
	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	Date	Vaccine
HAV (2)							
DTP (4*)							
Tdap (1)							
POLIO (3*)							
MEASLES (2)							
MUMPS (2)							
RUBELLA (2)							
MMR (2)							
HBV (3)							
MENINGOCOCCAL							
VARICELLA Date of 2 vaccines		/ /	/ /	Date of disease	/ /	DATE	RESULTS
MANTOUX TESTING REQUIRED FOR ALL HIGH RISK 1ST YEAR STUDENTS						/ /	
COVID 19			Provide Front & Back Copy of Covid Vaccine Card				

CARDIOVASCULAR HISTORY

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?
   Yes_____ No_____ If yes, please explain:

2) Past detection of a heart murmur or increased blood pressure?
   Yes_____ No_____ If yes, please explain:

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)?
   Yes_____ No_____ If yes, please explain:

CARDIOVASCULAR ASSESSMENT/TESTING

1) Auscultation to identify heart murmurs, especially any murmur suggestive of dynamic left ventricular outflow obstruction:

   Sitting _____ Standing _____

2) Evaluation of femoral artery pulses to exclude coarctation of the aorta:

Left _____ Right _____

3) Identification of any physical signs of Marfan's syndrome?

Yes _____ No _____

4) If indicated: EKG results: _____ Echocardiogram results: _____

Other: _____

This student may:

- ☐ Participate fully in the school program including athletic activities and competitive sports.
- ☐ Participate in the school program including athletic activities and competitive sports with the following restrictions/adaptation:

Oral Health Assessment

Dental Examination Completed by:

- ☐ Dentist Date: _____

Dental Screening Completed by:

- ☐ MD/DO
- ☐ APRN
- ☐ PA
- ☐ Dental Hygienist
  - ☐ Screening Normal
  - ☐ Screening Abnormal (Describe) _____

Referral Made:

- ☐ Yes
- ☐ No

Risk Assessment:

- ☐ Low
- ☐ Moderate
- ☐ High Describe risk factors identified: _____

Recommendation(s) by health care provider:

_____

Examiner's Name Typed or Printed: _____ Telephone: _____

Address: _____ Fax: _____

Signature: _____ Date: _____

PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION

Student name _____ Date of Birth_____

Physician's name _____

Phone _____ Fax _____

Diagnosis_____ Date of Diagnosis: _____

Allergies: _____

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.

MEDICATION 1

_____

_____

Everyday _____ Academics Only_____ This medication is optional/PRN: _____

MEDICATION 2

_____

_____

Everyday _____ Academics Only _____ This medication is optional/PRN: _____

MEDICATION 3

_____

_____

Everyday _____ Academics Only _____ This medication is optional/PRN: _____

I hereby request that the above ordered medication be administered by school personnel.

Physician's signature_____ Date_____

THE WOODSTOCK ACADEMY HEALTH SERVICES

TUBERCULOSIS SCREENING

Mandatory for all 1st year Woodstock Academy students.

All screenings must be performed within 1 month of admission to The Woodstock Academy.

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

Student Name: _____ Date of Birth: _____

Date of PPD (Mantoux) Plant: _____ Initial of Provider: _____
Date of Reading: _____ Initial of Provider: _____
Result (Read in millimeters):_____ Initial of Provider: _____

A Chest X-ray must be performed on all students with positive PPD Screening. Results must accompany this form.

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.

If other testing such as QuantiFERON Gold has been performed, please attach results to this form.

Signature of Physician/ Provider: _____
Address of Physician: _____

Phone number: _____
Email Address: _____