Health Forms
2020-2021

Complete and return to the school nurse, Nikki Jaffray (n.jaffray@georgestevens.org) **by August 1, 2020**.

George Stevens Academy
23 Union Street
Blue Hill, Maine 04614 USA
+1 (207) 374-2808
FAX: +1 (207) 374-2982

Medical Authorization Form

Student's Name: _____Birth Date: _____

Grade: _____ Male □ Female □ Allergies:_____

Parent's/Guardian's Full Name: _____

Home Phone: _____ Work Phone: _____

Parent's/Guardian's E-mail: _____ Fax: _____

Emergency Contact: _____ Phone: _____
(NOT Parent)

Agency Contact: _____ Phone: _____

Health Insurance is required for all students.

Please check **one** of the following options. Parents are responsible for all medical expenses.

1.) _____ My insurance covers my child in Maine (USA). I am attaching a copy of the front and back of my insurance card (required).

2.) _____ I would like to purchase insurance through the school. I understand that I will pay for this when I pay the tuition and fees for the year.

This form constitutes a permission statement **and must be signed by a parent or guardian**.

As long as my child is enrolled as a student at George Stevens Academy, I hereby give consent for George Stevens Academy to obtain any and all of the following care for my child: x-rays; dentist; immunizations; medical counseling; general health maintenance with a physician; group counseling; health seminars; psychological or medical evaluations; curative or maintenance counseling; crisis counseling; and emergency medical or psychological care and possible admissions to area hospitals, as needed. In case of surgical emergency, I hereby give permission to the Head of School or his/her designee to appoint any physicians/surgeons he/she considers appropriate to give emergency care, anesthesia, or perform emergency surgery. This permission will also cover obtaining alcohol and drug screening and the results of such testing, as deemed necessary by George Stevens Academy. I hereby give consent for the school nurse and/or authorized agent of George Stevens Academy to obtain and share pertinent protected health information. I understand that every effort will be made to contact parents/guardians in an emergency. I also understand that if my child's medical or psychological condition becomes serious enough, he/she may need to return home, and I will be responsible for the cost of my child's repatriation.

Signature of Parent/Guardian_____Date (MM/DD/YYYY)_____

Health History

(To be completed with the student's doctor)

Height _____ Weight _____ Date of birth _____ Country _____
(MM/DD/YYYY)

Your personal health history and record of physical examination (Positive replies will have no influence over the school's admissions decision.) Please answer every question. All "yes" answers marked with * require explanation in the space provided. Have you had:

	Y	N		Y	N
Albumin or sugar in urine*	□	□	Rupture, hernia	□	□
Anemia or blood problem*	□	□	Have you tested HIV positive? *	□	□
Frequent anxiety*	□	□	Insomnia	□	□
Back problems*	□	□	Jaundice*	□	□
High/low blood pressure*	□	□	Disease or injury of joints*	□	□
Shortness of breath	□	□	"Trick" knee, shoulder, etc.*	□	□
Chest pain/pressure*	□	□	Learning or speech disability*	□	□
Chicken pox	□	□	Malaria	□	□
Recurrent colds	□	□	Measles	□	□
Chronic cough*	□	□	Mumps	□	□
Diabetes*	□	□	Rheumatic fever/heart murmur*	□	□
Frequent depression*	□	□	Rubella	□	□
Recurrent diarrhea*	□	□	Scarlet fever	□	□
Dizziness, fainting*	□	□	Sinusitis	□	□
Ear, nose or throat trouble*	□	□	Skin problems (acne, etc)*	□	□
Epilepsy*	□	□	Sleepwalking	□	□
Irregular or severe periods (Females only)	□	□	Stomach or intestinal trouble*	□	□
			Tuberculosis*	□	□
Eye trouble*	□	□	Tumor, cancer, cyst*	□	□
Gallbladder trouble/gallstones*	□	□	Frequent urination*	□	□
Gum/tooth trouble*	□	□	Venereal disease*	□	□
Hay fever, asthma*	□	□	Weakness, paralysis*	□	□
Recurrent headache	□	□	Recent gain or loss of weight*	□	□
Head injury/unconscious*	□	□	Worry or nervousness	□	□
Heart palpitations*	□	□	Hepatitis (A,B,C)	□	□
			Self injury/Self harm	□	□

SURGERY

☐ Appendectomy ☐ Tonsillectomy ☐ Hernia repair ☐ Other (describe)

_____

ALLERGY

☐ Penicillin ☐ Bee sting ☐ Sulfonamides ☐ Foods/animals ☐ Medications

_____

TYPE OF REACTION TO ABOVE _____

DENTAL

Date of last dental check-up: _____ Does the student wear braces? ☐ Yes ☐ No

VISION

Date of last eye exam: _____ Does the student require corrective lenses? ☐ Yes ☐ No

Students who use corrective lenses **should take an extra pair** of eyeglasses or contact lenses to GSA.

HEARING

Does the student have impaired hearing? □ Yes □ No Does the student use a hearing aid? □ Yes □ No

OTHER HEALTH CONDITIONS

Has the student had any illness or injury or been hospitalized other than as already noted? □ Yes □ No

Has the student received treatment for a nervous condition, personality or character disorder, or emotional problem? □ Yes □ No

Has the student ever suffered from an eating disorder (anorexia or bulimia)? □ Yes □ No

Please explain any "yes" answers here: _____

_____

Physician's signature _____ Date _____

_____ Date _____

Record of Physical Examination

(To be completed with the student's doctor)

Blood pressure _____ Blood type _____ Temperature _____ Pulse _____ Respiration _____

	Y	N		Y	N		Y	N
Breasts	□	□	Musculoskeletal	□	□	Metabolic/endocrine	□	□
Cardiovascular	□	□	Pelvis (optional)	□	□	Teeth/gums	□	□
Eyes	□	□	Genito-urinary	□	□	Neurological	□	□
Gastrointestinal	□	□	Head, ears, nose, throat	□	□	Respiratory	□	□
Skin	□	□	Hernia	□	□			

Physician's comments (please use additional sheets if necessary):

1. Describe in detail each disease, impairment or abnormality indicated.

2. Describe type of allergy, allergen medication sensitivity, symptoms, treatment, medications and any required environmental limitations.

3. Are there any conditions now existing, which may require additional treatment? If yes, please explain.

4. Will the applicant be taking any prescription drugs or vitally needed non-prescription drugs to the US? If yes, please list drugs, how often taken, and why.

State of applicant's health: □ Excellent □ Good □ Fair □ Poor

Recommended physical activity: □ Limited □ Unlimited

Immunization record, type of vaccine, and required number of doses

	1st DOSE month/day/year	2nd DOSE month/day/year	3rd DOSE month/day/year	4th DOSE month/day/year	5th DOSE month/day/year
DPT &/or Td (5)					
DPT(>10 years ago)			XXXXXXXX	XXXXXXXX	XXXXXXXX
Polio (4)					XXXXXXXXX
Hepatitis B (3)				If students had measles, mumps, or rubella, give date of disease: Measles mm/dd/yy Mumps mm/dd/yy Rubella mm/dd/yy	
Measles (2)					
Mumps (2)					
Rubella (2)					
Chicken Pox (2)					
Meningitis (2)					

Tuberculin skin test result: □ Negative □ Positive _____ Type given _____ Date given _____

Tuberculin test is required six months prior to arrival in the U.S. If the test is positive, a report of negative chest x-ray is required.

I have reviewed the medical history of this applicant and completed a thorough physical examination and certify that all relevant medical information has been included. I further certify that the above information is complete and accurate. In my judgment, it provides all available information that might possibly prove necessary to those responsible for his/her health care in the US.

Printed Name of Physician: _____ Physician Signature: _____

Physician Address: _____ Date of examination: _____

Guidelines for Medication Administration

The following is a list of guidelines that must be followed for any medication to be administered at George Stevens Academy.

1. The school nurse must have written notification from the student's healthcare provider (on the school form or prescription pad) of the following:
    a. Name of the medication.
    b. Condition being treated.
    c. Dosage and times the medication is to be given.
    d. If the medication is other than an oral medication, the route should also be stated.

2. **All medications must be in their original container with the label intact. Whenever possible, labels should be in English. If they are in another language, then an English translation of the label should be given to the nurse. All containers must also be labeled to match the prescription written by the healthcare provider.**

3. All medication will be supplied to the nurse, either in person or through the mail in a timely fashion. Deviation from this policy may cause a delay or interruption in receiving the medication. **The nurse does not provide reminders.**

4. It is not considered ethical for healthcare providers to write prescriptions for their own children. Please seek the services of another healthcare provider.

5. Herbal and homeopathic medications in any form will be treated as medications, not as supplements. Please note that if any of these are found to be controlled or illegal substances in the U.S., then an acceptable alternative medication must be used instead.

6. Unclaimed medications shall be disposed of after 2 weeks. Controlled substances cannot be sent via mail.

7. **All medications must be administered by or under the direction of the nurse or dorm staff on duty.** This includes all over-the-counter medications, prescriptions, and anything that appears to be or takes the form of medicine. Antibiotics must be given to the school nurse. Students may administer their own vitamins but should give the nurse a list of what they are taking.

8. Bring an empty pharmacy labeled bottle with your child.

9. Refills are the sole responsibility of the parents/guardian. The nurse will not be responsible for medication refills even if a local physician is used.

MEDICATIONS BEING TAKEN

Please list all routine medications. This includes medications taken for a temporary illness and even over-the-counter medicines, which, according to a physician's orders, must be taken at a higher dosage than recommended on the packaging. Medications must be accompanied by a written statement from the prescribing physician detailing the administration of the medicine. Medications are distributed at breakfast (B), lunch (L), dinner (D), and bedtime (BT). The student should bring at least a one-month's supply when he/she first arrives at the school.

☐ This student takes NO medications on a routine basis.

☐ This student takes medications as follows:

Administered
(Circle all that apply.)

Med #1: _____ Dosage: _____ B L D BT

Reasons for taking: _____

Med #2: _____ Dosage: _____ B L D BT

Reasons for taking: _____

Med #3: _____ Dosage: _____ B L D BT

Reasons for taking: _____

*Please complete separate section on page 10 for an Asthma condition.

Additional Medication Information:

_____

_____

MEDICATION THAT SHOULD <u>NOT</u> BE ADMINISTERED

When students are sick at George Stevens Academy, it is often considered wise to provide them with over-the-counter medication for symptom relief, thereby increasing their comfort level. The dorm staff on duty, with the assistance of the nurse, may decide which medications are useful in illnesses not requiring a healthcare provider's evaluation. If there are any <u>medications that should not be administered</u> to the student, please list them here as well as the reason for this decision.

_____

_____

_____

PLEASE NOTE

Do not send over-the-counter medication with the student. Students are not permitted to have medication in their rooms, and these medications will be removed. Send only medication prescribed by a medical doctor/physician.

Parents/guardians are responsible for sending medication refills directly to the nurse. The nurse is not responsible for providing reminders when refills are needed. If you will be using a local pharmacy, please arrange for direct payment with them.

Local Pharmacies:

Rite Aid +1 (207) 374-3565

Community Pharmacy +1 (207) 374-3707

Medications needed for temporary illness, on a short-term basis, will be provided to that student at no extra expense. If the student requires long-term use of an over-the-counter medication, the nurse or dorm staff will provide him/her with a supply at the parent's expense, which will be dispensed only to this student.

As clearly stated in George Stevens Academy's Guidelines for Medications, all of the above mentioned medications may not be kept in a student's room. Providing a student with these medications to keep in his/her room can result in disciplinary action for the student.

_____ _____

Parent/Guardian's signature Date

ASTHMA MEDICATIONS

Some asthma medications are taken every day. These long-term control medications. Medications may be distributed at breakfast (B), lunch (L), dinner (D), and bedtime (BT). Please list medications/dosage taken <u>every day:</u>

☐ This student takes NO long-term control medications for asthma.

☐ This student takes medications as follows:

Administered
(Circle all that apply.)

Med #1: _____ Dosage:_____ B L D BT

Med #2: _____ Dosage: _____ B L D BT

Med #3: _____ Dosage: _____ B L D BT

Some asthma medications are increased when asthma gets worse. Please list medications/dosage that <u>can be increased</u> if asthma gets worse. (Example: Increase inhaler from 2 puffs to 2-4 puffs as needed.)

Administered
(Circle all that apply.)

Med #1: _____ Dosage:_____ B L D BT

Med #2: _____ Dosage: _____ B L D BT

Med #3: _____ Dosage: _____ B L D BT

Does the student have a peak flow meter? □ Yes □ No If yes, please take the peak flow meter to school.

If yes, please comment below on what your peak flow zones have been:

_____

_____

List possible/known allergies that have been asthma triggers:

_____

_____

TRAVEL MEDICATION POLICY

George Stevens Academy cannot assume responsibility for the medication needs of a child when traveling outside of the supervision of the school. The school will provide medications to students leaving campus for weekends or breaks, provided that the parent/guardian has provided the school with signed authorization and the prescribed medications are available.

I give _____ (name of student) permission to transport his/her medications from school to the location where he/she is traveling to spend the weekend and/or break. I assume all responsibility for the medication from the time it is given to my child until it is returned to the nurse or dorm staff at George Stevens Academy.

_____ _____

Parent/Guardian's signature Date

_____

Printed Name

_____ _____

Student's signature Date