All attached paperwork must be completed and mailed to the Health Center at least **one week prior to registration.** If you are unable to do this, please hand deliver to the Health Center on registration day.

Please use this checklist to help ensure that all forms are completed correctly. You will also find a copy of the Hyde School Health Center Medication Policy attached. Please review this policy.

**Part One – Forms to be completed by parent/guardian**

___ **Medical Emergency Consent/General Information**

___ **Please attach a copy of your current insurance cards – both sides**

___ **Medication Authorization Form**
   This form is required for all students even if they are not taking a prescription medication.

___ **Midcoast Pediatrics Consent**
   The Health Center primarily uses Midcoast Pediatrics for illness and injury; therefore, we need your signature on their consent form.

___ **MidCoast Hospital Authorization**-allows Health Center to gain access to records in the event of any student being seen at the hospital.

___ **Hyde School HIPPA** – allows the Health Center to share information and how best to contact you.

___ **Personal Medical History**

___ **Influenza Vaccine Consent**

**Part Two – Forms to be completed by the student’s physician**

___ **Physician’s Physical Examination/Immunization History**
   Each student must have a complete physical each year. Students will **not** be allowed to participate in any sport/wilderness activity without this completed form.

___ **Maine School Asthma Plan**
   The Maine School Asthma Plan must be completed by a physician if the student has been diagnosed with asthma.

___ **Physician’s Request for Medication Administration**
   No medication will be administered without a physician’s written order.
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 ____________________________

Social Security Number ______________________

Home Address ____________________________________________________________

Student resides with: Both Parents ______ Father ______ Mother ______ Other ______

Father's full name ___________________________ #1 Phone ( )

Address if different than student's _____________________________________________

Mother's full name ___________________________ #2 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 _____ (Provide Copies of front and back of insurance cards)

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

Name of policy holder ___________________________ SSN __________

Address of policy holder _______________________________________________________

Policy holder's employer ___________________________ Policy holder's D.O.B. __________

** 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, Hyde School Faculty, 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). I also authorize the Health Services Department of Hyde School to share medical information (physical and/or mental health) with employees of Hyde School 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 Hyde School 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 Hyde School Faculty to give consent for necessary anesthesia and emergency surgical procedures on my (son, daughter, ward).

Parent/Guardian Name: ___________________________ Date: ___________________________

Signature: ___________________________ Relationship: ___________________________
HYDE SCHOOL MEDICATION POLICY

Bath Campus

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 student and medication on it. The Health Center will not accept improperly labeled containers.
3) Only a limited supply of medication will be kept at school.
4) All students are to receive adequate instruction from the prescribing physician regarding the self-administration, desired effect, and side effects of all medications.
5) A Physician’s Request for Medication Administration form must accompany all prescription and non-prescription medications (including vitamins, supplements, and homeopathics). Hyde School does not allow the use of any products containing creatine or nicotine. 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.
6) A Medication Authorization form must be completed and signed by the parent(s) and student.
7) No medications or supplements are allowed in student rooms without Health Center authorization.
8) Your child's student bank account will be charged a medication distribution fee in the amount of $150 per trimester for each trimester that the Health Center administers medication to them.

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.

MEDICATION RESPONSIBILITIES

PARENT / GUARDIAN RESPONSIBILITES

1) The parent is responsible for obtaining all paperwork needed by the physician’s office with respect to medication.
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.
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.

STUDENT RESPONSIBILITES

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.
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.

HYDE HEALTH CENTER RESPONSIBILITES

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) Entire supplies of medication will be mailed home at the end of the summer session and end of the school year with parental permission. All medications remaining in the Health Center following school closing will be destroyed.
MEDICATION AUTHORIZATION FORM

Must be completed for all students.

Student Name: ______________________________  Date: __________________

Parent / Guardian Name: ______________________________

I have reviewed the enclosed Hyde School Medication Policy and give permission to
the school nurse or designee to administer prescription medication as ordered by my
son’s / daughter’s physician or Hyde School’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 Hyde
School 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 med.)

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 Hyde School 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)
May 29, 2014

To Hyde School Parents:

Midcoast Pediatrics is very pleased to be the school physicians for Hyde School students. We are dedicated to doing everything possible to make your child’s healthcare issues as easy as possible while at Hyde School.

We are pleased to submit any visits that the student may have in our office to your insurance. However, it is imperative that we are kept up to date with your most current insurance plan. We will submit to the insurance, if they have not paid the visit in 60 days, then the balance due will be your responsibility.

Insurance companies expect payment for co-pays at the time of service and our office policy does require all patients to pay their co-pays the same day they are seen.

We are happy to take credit card information on the phone the day of the appointment. We accept Visa, MC and American Express (please note that for your protection we do not keep credit card numbers on file).

It has always been our pleasure to work with students from the Hyde School and we look forward to helping you and your child in any way that we can.

Sincerely,

David L Enright M.D.
I acknowledge that Midcoast Pediatrics regards the safeguarding of my child’s protected health information (“PHI”) as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my child’s protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my child’s relationship with Midcoast Pediatrics. It is the policy of Midcoast Pediatrics that PHI is confidential and shall not be improperly disclosed. Your child’s PHI shall not be disclosed unless disclosure is permitted by law or you have specifically authorized the disclosure.

Parental Consent for Treatment, Consent to Use and Disclosure of Protected Health Information (“PHI”) and Assignment of Benefits

1. Consent for Treatment
   I hereby consent to and authorize Midcoast Pediatrics, its physicians, employees and other individuals involved in this care to administer such diagnostic procedures or treatment or both as may be advisable to evaluate and treat my child’s injury or illness. I understand that the physician responsible for my child’s care has the responsibility to explain to me the purpose, of, benefits of, and the usual and most frequent risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative course of treatment. I further understand that I have the right to refuse any suggested examinations, tests or treatment. I understand that Midcoast Pediatrics requests my consent to ensure that Midcoast Pediatrics can properly carry out the professional responsibility of caring for my child.

2. Consent to Use and Disclosure of Protected Health Information
   I consent to Midcoast Pediatrics disclosure of PHI to other health care practitioners and facilities that are involved in providing medical services to my child, my family, and close friends who are providing my child with emotional support as my child receives medical services. Also, I consent to Midcoast Pediatrics disclosure of PHI to my child’s health insurance carrier, utilization review organization, or third-party administrator to support payment for my child’s medical services. I understand that Midcoast Pediatrics will disclose only the minimum amount of my child’s health care information which is necessary, in the judgment of Midcoast Pediatrics, for the legitimate needs of the recipient or for my child’s general well being. I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier. I may revoke my consent at any time by providing Midcoast Pediatrics with a written, signed, and dated request, except to the extent that Midcoast Pediatrics has acted in reliance upon my consent. However, I understand that restriction of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I understand that if I have any questions about this consent, or if I wish to have a copy of this consent, I may ask the office staff or my child’s physician.

______________________________________________________________________________
Signature of Patient or Parent/Legal Guardian  Date

______________________________________________________________________________
Patient’s Name  Relationship to Patient

3. Payment and/or Assignment of Benefits
   I understand that I am responsible for the payment of all charges associated with this treatment. I further understand that I am financially responsible in the event that payment is denied or rejected by my health insurance carrier(s) or third parties, and for those charges not covered by the policy benefits as deductible and co-insurance or otherwise not covered by this assignment. I hereby authorize payment from my health insurance carrier(s) or other financially responsible parties, directly to Midcoast Pediatrics to the extent necessary to pay for this treatment.

______________________________________________________________________________
Policyholder  Date
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: ____________________________

Last               First               Middle

Home Address: ____________________________________________

Home Telephone: ____________________________ Date of Birth: ____________________________

Social Security Number: ____________________________

DATE(S) OF SERVICES: ____________________________ ____________________________

Notice: Per state and Joint Commission requirements, Mid Coast Hospital is required to retain patients' medical records "for a minimum of ten (10) years after the patient visit date, with the exception of a minor, whose record shall be maintained at a minimum to the age of majority (18) plus six (6) years." Therefore, we will not fulfill requests for records for visits more than 10 years prior to the records request date. The exception is a request involving the medical record(s) of a minor (18 plus six (6) years).

SPECIFY INFORMATION TO BE DISCLOSED:

☒ Discharge Summary ☐ Diagnostic Imaging report(s) ☒ Cardiopulmonary
☒ History & Physical ☐ Diagnostic Imaging film ☐ Progress Notes
☒ Consultation Report(s) ☐ Pathology Report(s) ☐ Provider Orders
☒ Operative Report(s) ☐ Laboratory Report(s) ☐ Partial Hospital Record
☒ Emergency Record ☒ Summary of hospital visit ☐ Sleep Laboratory
☐ Other: ____________________________

I understand that this authorization may be withdrawn at any time by written notification only, and that unless withdrawn, will remain in effect for the term established below. Recipients of this information are prohibited from re-disclosure without my written permission.

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing my name below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated.

☒ Mental Health
☒ HIV/AIDS Test Results, Status, Treatment
☒ Substance (i.e., alcohol or drug) Abuse/Treatment
☒ Domestic Violence, Sexual Assault

I understand that authorization to release this highly confidential information requires my signature each time information is requested.

_________________________________  ____________
Signature of Patient                Date

RECIPIENT:

Name of person or class of persons to whom Mid Coast Health Services may disclose my health information:

______________________________

Hyde School Health Center

Address of the recipient or where my health information should be delivered:

______________________________  ____________________________
616 High Street, Bath, ME 04530     Fax: 207-443-7187

TERM:

This Authorization will remain in effect:
☐ Until Mid Coast Health Services fulfills this request.

PURPOSE:

I authorize Mid Coast Health Services to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

☐ For my further care
☐ To process my claim
☐ Other: ____________________________

FRMMHS-002009 (10/12)
I understand that once Mid Coast Health Services discloses my health information to the recipient, Mid Coast Health Services cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Mid Coast Health Services may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization by written notification only for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Mid Coast Health Services; except, however, if my treatment at Mid Coast Health Services is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Mid Coast Health Services may refuse to treat me if I do not sign this Authorization.

I understand that if I refuse to sign or revoke this authorization, it may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other insurance or other adverse consequences.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Mid Coast Health Services at the address listed below. The revocation will be effective immediately upon Mid Coast Health Services receipt of my written notice, except that the revocation will not have any effect on any action taken by Mid Coast Health Services in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Mid Coast Health Services to use or disclose my health information in the manner described above.

______________________________  __________________________  __________________________  __________________________
Signature of Patient or Legally Authorized Representative  State Relationship  Date/Time  Print your name
PERSONAL MEDICAL HISTORY

Student’s Name ___________________________ Date ___________________________

This information is for the use of Health Services in providing necessary health care while you are a student at Hyde School. This is to be filled out by a parent/guardian. All questions must be answered.

FAMILY HISTORY: Has anyone in your family had any of the following? (Parent, Sibling, Aunt, Uncle, Grandparent)

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Year of Death</th>
<th>Y / N</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PERSONAL HISTORY:
List all allergies and reactions:

List all surgeries / hospitalizations and dates:

Has student received psychiatric treatment or counseling for a personality or character disorder, drug/alcohol, eating disorder, self-inflicted behavior, or an emotional problem with the last 5 years? □ No □ Yes Dates: ____________

Explain: ____________________________________________________________

Has your physical activity been restricted in the past five years? □ No □ Yes Dates: ____________

Explain: ____________________________________________________________

Please check all that apply to student:

**NO PROBLEMS**

Eyes                      Cardiovascular      Endocrine      Musculoskeletal
□ Blurred Vision          □ Chest Pain       □ Thyroid       □ Joint Swelling
□ Vision Changes          □ High Blood Pressure □ Diabetes      □ Joint Pains
□ Glasses/Contacts*       □ Murmur                □ Mono          □ Muscle Pains
Ear/Nose/Throat           □ Heart Problems      □ Urinary       □ Freq Sprains
□ Sinusitis               □ Hematological        □ Infections   □ Fractures (Dates)
□ Allergies               □ Anemia                 □ Burning       □ Back Problems
□ Tonsillitis             □ Bleeding Disorder    □ Blood with urination □ Skin
□ Strep Throat            □ Hepatitis             □ Difficulty   □ Rash
□ Ear Infections          □ Neurological          □ Gastrointestinal □ Eczema
Respiratory               □ Headaches            □ Reflux        □ Changing Mole
□ Chronic Cough           □ Migraines            □ Ulcer         □ Mental Health
□ Shortness of Breath     □ Seizures              □ Constipation  □ Insomnia
□ Asthma                  □ Head Injury           □ Blood in stool □ Depression □ Anxiety
□ Bronchitis              □ with loss of consciousness □ Abdominal Pain □ Suicidal Ideations
□ History of Pregnancy   □ Severe Cramps
                          □ Irregular Periods *Students that wear contacts MUST also have eye glasses in case of eye or contact problems *

Date of Last Dental Exam: ____________

**Please use reverse side to explain all checked areas in detail. If faxing, be sure to include back side.**
Hyde School Bath – Health Office
Phone Number: (207) 443-7186    Fax Number: (207) 443-7187

Please return this completed form with your medical information. **We will use this information when calling home regarding your child’s health and medication status.**

**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 # ________________________________
___ DO NOT leave message
___ Leave brief message, caller name and return #
   (Caller’s name, phone number, brief message)
___ May leave detailed message

E-Mail ________________________________
___ 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: ______________
INFLUENZA VACCINE 2014-2015 HEALTH SCREEN & PERMISSION FORM

Full Name: 
Date of Birth: / / 
Age: 
Gender: □ M □ F
Street Address: 
Town/City: 
Zip Code: 
Daytime Phone: 
Grade: 
Teacher: 
School Administrative Unit (District)

Please answer the following questions about the person named above. Comments may be written on the back of this form.

1) Does this person have a severe (life-threatening) allergy to eggs?

2) Has this person ever had a severe reaction to an influenza immunization in the past?

3) Has this person ever had Guillain-Barre Syndrome?

4) Has this person received any other vaccinations in the past 4 weeks, or is not feeling well?
   If yes, Type of vaccine ________ Date ________

5) Does this person have long-term health problems, allergies, asthma or wheezing problems, or on long-term aspirin treatment?

6) Does this person have a weakened immune system, or come in close contact with someone who has a severely weakened immune system? Explain:

7) Is this person pregnant or could this person be pregnant?

If you answered “yes” to any questions 1-3, please see your healthcare provider for flu vaccination

If you answered “yes” to any questions 4-7, this person cannot receive the Intranasal flu vaccine

8) Is this person an American Indian or an Alaskan Native?

9) Is this person uninsured?

10) Is this person insured by MaineCare (Medicaid)?
    MaineCare ID #:

11) Health Insurance: Name of Company:
    ID Number: __________________ Group number: __________________
    Subscriber Name: __________________ Subscriber Date of Birth: __________________

12) Doctor’s Name: __________________ Phone Number: __________________

PERMISSION TO VACCINATE

I was given a copy of the 2014-2015 Influenza Vaccine Information Statements, I have read them or had them explained to me and I understand the benefits and risks of the Influenza vaccine.

I give permission for a record of this vaccination to be entered into the Influenza Registry.

I give permission for information to be used to bill MaineCare or private insurance for the cost of providing the vaccine.

I give my consent for this person to receive the most appropriate vaccine, as determined by the clinic health care staff.

If my child refuses to receive the injection and does not have any of the conditions #4-7 listed above, you have my permission to give the nasal flu mist.

I give permission for the flu vaccine to be given to the person named above by signing below.

X __________________ Date: __________________

Signature of parent or guardian if person to be vaccinated is a minor or Signature of adult to be vaccinated

Printed Name of Parent/Guardian or Adult to be Vaccinated

FOR OFFICE USE ONLY:

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Vaccine Manufacturer</th>
<th>Lot Number</th>
<th>Dose Volume</th>
<th>Signature and Title of Vaccinator</th>
<th>Body Site</th>
<th>Route</th>
<th>VIS date</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Part Two

The following pages are to be completed by a physician.
Name of Student ___________________________ Date of Birth ___________________________

Allergies ___________________________ Date of Exam ___________________________

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>B/P</th>
<th>Respirations</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Tonsils</td>
<td>Thyroid</td>
<td>Kidneys</td>
<td></td>
</tr>
<tr>
<td>Hair</td>
<td>Teeth</td>
<td>Breast</td>
<td>Hernia</td>
<td></td>
</tr>
<tr>
<td>Nails</td>
<td>Gums</td>
<td>Lungs/Thorax</td>
<td>Genitalia</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Mouth</td>
<td>Heart</td>
<td>Rectum</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>R 20/ L 20/</td>
<td>Tongue</td>
<td>Abdomen</td>
<td>Back/Spine</td>
</tr>
<tr>
<td>Ears</td>
<td>Nose</td>
<td>Liver</td>
<td>Extremities</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Nodes</td>
<td>Spleen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 below for testing results)

---

**IMMUNIZATION HISTORY**

*Last dose must be given on or after 4th birthday (D.P.I.P. and D.T.P.)*

<table>
<thead>
<tr>
<th>PRIMARY IMMUNIZATION SERIES</th>
<th>Other Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1ST DOSE MO/DAY/YR</td>
<td>Date</td>
</tr>
<tr>
<td>2ND DOSE MO/DAY/YR</td>
<td></td>
</tr>
<tr>
<td>3RD DOSE MO/DAY/YR</td>
<td></td>
</tr>
<tr>
<td>4TH DOSE MO/DAY/YR</td>
<td></td>
</tr>
<tr>
<td>5TH DOSE MO/DAY/YR</td>
<td></td>
</tr>
</tbody>
</table>

**VACCINE TYPE**

- 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**  / /

Examiner’s Name Typed or Printed: ___________________________ Telephone: ___________________________

Address: ___________________________ Fax: ___________________________

Signature: ___________________________ Date: ___________________________

*** PLEASE COMPLETE PAGE 2 ***
Student's Name: ________________________________

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: ________________________________________________

________________________________________________________________________

Examiner's Signature  Date
### Green Zone

**Good!**

**Look For These Signs**
- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities

**What You Should Do**
- Take your **Daily Controller Medicines**
- Exercise regularly
- Medicine to take before exercise:
- Avoid your triggers:
  - Tobacco smoke

**Notes:**

**Peak Flow**

---

### Yellow Zone

**Caution!**

**Look For These Signs**
- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)

**What You Should Do**
- Keep taking your daily controller medicine
- Begin using **Quick Relief Medicine**
  - every 4-6 hours as prescribed (Prime it first, if needed)
- **Notes:**
  - If not better in 24-48 hours, call your doctor or nurse!
  - If at school, call parent

**Peak Flow**

---

### Red Zone

**Danger!**

**Look For These Signs**
- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping

**What You Should Do**
- Get help now
- Take a nebulizer treatment **or** Take 4 puffs of quick relief medicine now

**Call Your Doctor or Nurse Now!**

**Peak Flow** less than

---

**Classification:**
- [ ] Intermittent
- [ ] Mild Persistent
- [ ] Moderate Persistent
- [ ] Severe Persistent

**Daily Controller Medicines**

<table>
<thead>
<tr>
<th>Medication</th>
<th>How Much</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmicort Raspules</td>
<td>times/day</td>
<td></td>
</tr>
<tr>
<td>Pulmicort Flexhaler</td>
<td>times/day</td>
<td></td>
</tr>
<tr>
<td>Flovent</td>
<td>times/day</td>
<td></td>
</tr>
<tr>
<td>Singular</td>
<td>At bedtime</td>
<td></td>
</tr>
<tr>
<td>Asmanex</td>
<td>times/day</td>
<td></td>
</tr>
<tr>
<td>Symbicort</td>
<td>2 puffs</td>
<td>2 times/day</td>
</tr>
<tr>
<td>Advair</td>
<td>times/day</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Quick Relief Medicine**

<table>
<thead>
<tr>
<th>Medication</th>
<th>How Much</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaler</td>
<td>Nebulizer</td>
<td>Med:</td>
</tr>
<tr>
<td>Dose:</td>
<td>Frequency:</td>
<td></td>
</tr>
<tr>
<td>Inhaler</td>
<td>Nebulizer</td>
<td>Med:</td>
</tr>
<tr>
<td>Dose:</td>
<td>Frequency:</td>
<td></td>
</tr>
</tbody>
</table>

**REMINDER:** Get a Flu Shot

<table>
<thead>
<tr>
<th>School:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse:**
- Yes [ ]
- No [ ]

**Maine law permits students to carry and use inhaled medicines and epi-pen after demonstrating appropriate use to the school nurse. Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)**

**Healthcare Provider Signature**

**School Nurse Signature**

**Parent Signature**

---

**Physicians:** Fax completed copy to school nurse

**Parents:** Keep this handy
PHYSICIANS REQUEST FOR MEDICATION ADMINISTRATION

Student Name: ___________________________  D.O.B. ________

Student Allergies: __________________________________________

Physicians Name: ___________________________  Phone # ________

Address: ___________________________________________      Fax # ____________

Student must receive adequate instruction from their prescribing physician regarding the administration, desired effect, and side effects of all medication.

• MEDICATION ___________________ Diagnosis ___________  Daily Dose ___mg

Time/Dosage to be administered:  □ Every day  OR  □ Academics only

□ 7AM (Breakfast) ___________mg. □ PRN  □ 6PM (Dinner) ___________mg. □ PRN

□ 1PM (Lunch) ___________mg. □ PRN  □ 10 PM (Bedtime) ___________mg. □ PRN

Other: __________________________________________

• MEDICATION ___________________ Diagnosis ___________  Daily Dose ___mg

Time/Dosage to be administered:  □ Every day  OR  □ Academics only

□ 7AM (Breakfast) ___________mg. □ PRN  □ 6PM (Dinner) ___________mg. □ PRN

□ 1PM (Lunch) ___________mg. □ PRN  □ 10 PM (Bedtime) ___________mg. □ PRN

Other: __________________________________________

Discontinue the following medications:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

** Physician’s Signature: ___________________________  Date: _________

*** Please use back side to continue medication orders ***
PHYSICIANS REQUEST FOR MEDICATION ADMINISTRATION

Student Name: ___________________________  D.O.B. ________

- MEDICATION _______________ Diagnosis ___________  Daily Dose ___ mg
  
  Total
  
  Time/Dosage to be administered:  □ Every day  OR  □ Academics only
  
  □ 7AM (Breakfast) _________ mg. □ PRN  □ 6PM (Dinner) _________ mg. □ PRN
  
  □ 1PM (Lunch) ____________ mg. □ PRN  □ 10 PM (Bedtime) _______ mg. □ PRN
  
  Other: ______________________________

  Total

- MEDICATION _______________ Diagnosis ___________  Daily Dose ___ mg
  
  Time/Dosage to be administered:  □ Every day  OR  □ Academics only
  
  □ 7AM (Breakfast) _________ mg. □ PRN  □ 6PM (Dinner) _________ mg. □ PRN
  
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  Other: ______________________________

- MEDICATION _______________ Diagnosis ___________  Daily Dose ___ mg
  
  Time/Dosage to be administered:  □ Every day  OR  □ Academics only
  
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  □ 1PM (Lunch) ____________ mg. □ PRN  □ 10 PM (Bedtime) _______ mg. □ PRN
  
  Other: ______________________________

Discontinue the following medications:

__________________________________________________________________________

__________________________________________________________________________

** Physician’s Signature: ___________________________  Date: ________