HEALTH CENTER
REGISTRATION PACKET
For New Students
健康中心新生注册包

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.
包裹内的所有文件必须在开学注册前至少一个星期填写完成，并寄到学校健康中心。如果您无法将资料寄到健康中心，请在注册的时候交给健康中心。

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.
请使用以下清单检查您的资料是否齐全。包裹内还有一份海德学校健康中心药物使用政策，请阅读。

Part One – Forms to be completed by parent/guardian 第一部分：请家长/监护人填写

____ Medical Emergency Consent/General Information 紧急医疗同意书/基本信息

____ Please attach a copy of your current insurance cards – both sides 请附上您的保险卡附件—正反两面

____ Medication Authorization Form 药物治疗授权表

This form is required for all students even if they are not taking a prescription medication.

所有学生必须填写这份表格，即便学生不服用处方药

____ Midcoast Pediatrics Consent ---Midcoast 儿科医疗同意书

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

学校健康中心一般使用 Midcoast 医院的儿科医生为学生进行治疗，因此我们需要您在同意书上签字，否则我们无权送学生去医院接受治疗

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

MidCoast 医院授权书：同意学校健康中心查看学生在医院的就诊病例及信息

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

海德学校 HIPPA（学生健康情况信息表）：同意健康中心阅读学生健康信息并且提供有效的联系方式
Part Two – Forms to be completed by the student’s physician

Physician’s Physical Examination/Immunization History 体检/疫苗史
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 缅因学校哮喘计划书
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 医生对处方药的要求
No medication will be administered without a physician’s written order.

如果学生有哮喘的话，学生的医生必须填写缅因学校哮喘计划书
没有医生的书面要求学生不得使用处方药
Part One

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**  
**GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
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<table>
<thead>
<tr>
<th>Home Address of Student</th>
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<tbody>
<tr>
<td>Number and Street</td>
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</table>

<table>
<thead>
<tr>
<th>Student resides with:</th>
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<tbody>
<tr>
<td>Both Parents</td>
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<table>
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<tr>
<th>Father's full name</th>
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<tr>
<td>Res. Phone ( )</td>
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<table>
<thead>
<tr>
<th>Street Address</th>
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<tr>
<td>Bus. Phone ( )</td>
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<table>
<thead>
<tr>
<th>City, State &amp; Zip</th>
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<tr>
<td>Cell Phone ( )</td>
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<table>
<thead>
<tr>
<th>Mother's full name</th>
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<tr>
<td>Res. Phone ( )</td>
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<table>
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<tr>
<th>Street Address</th>
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<td>Bus. Phone ( )</td>
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<th>City, State &amp; Zip</th>
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<td>Cell Phone ( )</td>
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<table>
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<tr>
<th>Name of Medical Insurance Company</th>
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<td>Phone ( )</td>
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<tr>
<th>Address for insurance company</th>
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<tr>
<th>Pre-authorization required?</th>
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<tbody>
<tr>
<td>Yes</td>
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<tr>
<th>Certificate/Policy numbers (include group number if applicable)</th>
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<table>
<thead>
<tr>
<th>Name of policy holder</th>
<th>SSN</th>
<th>Date of Birth</th>
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<th>Address of policy holder</th>
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<table>
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<tr>
<th>Policy holder's employer</th>
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<table>
<thead>
<tr>
<th>Alternate responsible person (not parent) to be reached in case of emergency if parent or guardian is unavailable:</th>
</tr>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<td>------</td>
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</table>
Student's known allergies: ____________________________________________

Medication student currently taking: ____________________________________________

Pertinent Medical History: ____________________________________________

Physical Limitations: ____________________________________________

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.

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).

Name: __________________________ Date: __________________________

Signature: __________________________ Relationship: __________________________

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HYDE SCHOOL MEDICATION POLICY

海德学校医药政策

Bath Campus

巴斯校区

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:

学校会将药发给需要服用处方药的学生，但是他们必须在学校护士或者学校其它工作人员的监督下进行服用，同时他们必须满足以下条件：

1) Student will be evaluated by his/her prescribing physician at least once annually.
   学生至少由他/她的医生一年检查一次。

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.
   所用药物必须装在原装药瓶或包装盒内，并且清楚的表明学生姓名，直接送到健康中心内。健康中心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). Hyde School 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）都必须伴有医生的同意书。海德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.
   未经健康中心允许，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.

违反用药规定的学校将在教务处的监督下根据个人情况进行处理。请注意健康中心不会让学生张开嘴检查他们是否已经吞下了药物。

MEDICATION RESPONSIBILITIES

医药责任

PARENT / GUARDIAN RESPONSIBILITIES 家长/监护人的责任

1) The parent is responsible for obtaining all paperwork needed by the physician’s office with respect to medication.
   家长有责任提供所有和所用药物有关，医院需要的文件。
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.

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 RESPONSIBILITIES 学生责任

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 RESPONSIBILITIES 海德健康中心责任

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.
药物治疗授权表
所有学生务必填写

学生姓名: ____________________________ 日期: ______________

家长/监护人: ____________________________

1) 我已阅读并同意学校的医疗政策并同意学校的护士以及被指派者按照家庭医生或校医的指示来给我的儿子/女儿开处方药和非处方药。

家长姓名首写字母: ______

2) 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高量的活动)。

家长姓名首写字母: ______

3) 我允许我的儿子/女儿携带并使用下列紧急药品: 吸入器、哮喘药物，或肾上腺素自动注射器。

家长姓名首写字母: ______

4) 我知道学生放假回家时不携带任何药物。

家长姓名首写字母: ______

5) 您允许您的孩子在学年以及暑假活动结束时携带药物回家吗？允许______ 不允许_____ （如果家长不同意孩子携带药物回家，家长必须以手写形式通知学校健康中心药物的邮寄地址。）

家长姓名首写字母: ______

6) 我已阅读了学生有关药物的责任、并同意遵守其内容。

家长姓名首写字母: ______

家长签名: __________________________________
学生签名: __________________________________
海德学校的家长们：

Midcoast 的儿科医生都非常荣幸能为海德学校的学生看病。我们一定会竭尽全力保证您的子女在海德学校期间的健康。

当您的子女前来就诊时，我们非常乐意和保险公司合作，将他们每次就诊的医疗费上报给保险公司。由此，我们需要您最新的有效保险信息。如果保险公司在我们把医疗费信息报送之后六十天内没有付款，学生家长则有责任支付学生花的医疗费。

保险公司一般期待您在看病的同一天支付您所需负担的那一部分医疗费，我们医院也要求所有病人在看病当天支付自己需承担的费用。为了让这一程序简单化，我们提供以下几种选择。

家长可以在当天通过电话告诉我们信用卡信息。我们接受 Visa，MC，American Express 和 Discover ( 为了您的信用卡安全着想，我们不会将您的卡号记录在案。 ) 您也可以使用 Paypal 账户进行网上付费。您可以在 www.midcoastpediatricspa.com 开启一个新的账户，在 Billing 那一栏用 Paypal 进行付款。能和海德的学生合作是我们的荣幸，感谢您选择我们医院。

Sincerely,

David L Enright M. D.
我同意 Midcoast Pediatrics 负责保护本人子女受到保护的健康信息（PHI）。我知道这份同意书的内容是受到联邦政府法律要求，为了保护本人子女，支持本人子女和 Midcoast Pediatrics 之间的合作关系并且保证对 PHI 的使用合理化而制定。根据 Midcoast Pediatrics 的公司政策，PHI 属于机密信息，绝对不能随意向外界传播。贵子女的 PHI 在未经法律或您本人的许可之前不得向任何人透露。

家长医疗同意书，使用受保护的健康信息（“PHI”）同意书以及相关福利

1. 医疗同意书
我特此同意 Midcoast Pediatrics 的医生，职员以及其它工作人员参与对本人子女伤情，病情的医疗诊断并且提供合适明智的治疗。我知道医生在治疗本人子女的伤病时，有责任向我解释诊断和治疗的目的和益处，治疗有可能引起的副作用以及其它可行的医疗方案。我同样也知道我有权拒绝医生提议的体检，检查或治疗。我知道 Midcoast Pediatrics 需要我的委托书来确保 Midcoast Pediatrics 能够以专业态度合理的照顾好本人子女。

2. 使用受保护的健康信息同意书
我准许 Midcoast Pediatrics 向其它负责照顾本人子女的单位和个人提供相关的 PHI 信息，包括子女所在的健康中心以及在精神层面上参与照看她/他的家庭和朋友。同时，我也允许 Midcoast Pediatrics 将 PHI 信息提供给本子女的医疗保险公司，医疗费使用查询机构以及任何参与支付本子女医疗费用的第三方。我知道 Midcoast Pediatrics 会根据判断，出于对本子女的考虑而仅仅透露合情合理的必要信息。我了解这份同意书自签字起即开始生效，时效 30 个月，除非我本人提前撤销使同意书失效。在任何时候，我都能通过书面方式向 Midcoast Pediatrics 终止同意书，在书面文件中，我必须签字许可，提供准确的时间日期。然后，对于之前 Midcoast Pediatrics 经过我同意而延展出去的文件或行为将不受终止同意书这一行为的影响。同时，我知道对这份同意书的限制有可能导致不适当的诊断或治疗，保险公司拒赔或者其它相关后果。

我知道如果我对这份同意书有任何问题，或者需要一份同意书的副本，我都可以向本人子女所在医疗机构的工作人员提出要求。
3. 付款和相关福利
我知道我应对此项治疗相关的的收费负责。我也知道当保险公司，第三方团体或个人无法支付医疗费用时，我应支付相关费用。我在此同意我的保险公司或其它相关财务公司向 Midcoast Pediatrics 支付与此次治疗相关的费用。

__________________________________________
保险客户

__________________________________________
日期
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

姓名 name: __________________________________________________________
姓 last 名 first 中间名 middle

家庭住址 home address: ____________________________________________

家庭电话 home phone: ____________________________ 出生日期(DOB): _________________________

社会安全号 SSN: _________________________________________________

Specify Information to be disclosed/dated of service 需使用或记录的信息服务:

___Abstract 摘要 ___Diagnostic Imaging Report/Films 诊断用的影片报告 ___Progress Notes 进展笔记/病历
___Discharge Summary 执行总结 ___Laboratory Reports 验血报告 ___Physicians Orders 医嘱
___History &Physical 病史和体检报告 ___Operative Report 手术报告 ___Emergency Dept. Record 急诊部记录
___Consult Report(s) 咨询报告 ___Pathology Report 病理报告 ___Partial Hosp. Record 部分医院记录
___Cardiopulmonary 心肺检查 ___Sleep Lab 睡眠测试 ___Addiction Resource Record 上瘾资源记录
___Other 其它

My highly confidential information 我的最高保密信息:

通过在最高保密信息类别后签名的方式，我在此授权准许使用，或公布我的签名那一栏相对应的信息

- Information about a Mental Illness or Developmental Disability
  （关于精神疾病或者生长残疾的信息）_____________________________________
- Information about HIV/AIDS Test Results, Infection Status or Treatment
  （关于艾滋病的测试结果，病情和质量方案）________________________________
- Information about Substance (i.e. alcohol or drug) Abuse
  （关于滥用物品，比如酗酒或滥用药物等的信息）_________________________
Recipient 接受者：
写下允许 Midcoast 健康服务中心向其给予健康信息的个人或团体（如学校，老师等）

接受健康信息者的地址：

Term 条件：
这份授权书保持有效：
__From the date of this Authorization until the________ day of________，20__
从签署这份授权书的那天直到________日________月________年
__直到 Mid coast 医院完成执行请求。
__直到以下事件发生__________________________

Purpose 目的：
在为了满足以下目的情况下，我授权 Mid Coast 医院在此学期使用或公布我的健康信息（包括我选择的最高保密信息，如果有的话）
__为了我今后的健康 for my further care
__为了领取保险费 for my claim
__其它 other：__________________________

本文所要求的信息包括机密信息和其它特别信息。其信息有可能以书面形式或电子形式（CD，磁盘，U盘）进行传递和使用。
所泄露的信息仅供指定获取人使用，任何未经允许的使用，泄露和发布将由获取人负责。
我知道一旦MidCoast医院将我的信息提供给获取人，MidCoast医院则无法保证获取人不会将我的信息泄露给第三方。收到信息的第三方也许不会被要求遵守本授权书或其它相关联邦法律。
我知道MidCoast医院可以通知直接或间接方式从使用我健康信息的第三方获得赔偿金。
我知道我可以以任何原因拒绝签订或中断（任何时间）此授权书，此举不会影响我在MidCoast医院的治疗。然而，如果我的在MidCoast医院治疗的唯一目的是为了给我在此授权书中给出的获取人提供健康信息的话，MidCoast有权拒绝为我提供服务。
我知道拒绝或中断此授权书也许会导致不适当的诊断，治疗，保险拒付或者无法获得保险赔偿金等
我知道此授权书会一直有效，直到超过有效日期或由我根据以下地址向MidCoast医院提供书面通知。此委托书在医院接到书面通知的同时会立即失效，但是中断委托书对于MidCoast医院在收到书面通知之前所采取的行动没有任何影响。我可以通过邮寄方式联系MidCoast医院健康信息管理中心，其地址为：Mid Coast Hospital, 123 Medical
Center Drive, Brunswick, Maine 04011，电话号码：207-373-6283。

我已阅读并理解授权书中的条款，并且我有机会就使用和公布我的健康信息而提问。通过在此文签字，我在此自愿授权Mid Coast医院在以上所述条件满足的情况下使用并公布我的健康信息。

Signature of Patient Date就诊人签字_________________________________ Date日期________________________

如就诊人为未成年人或无法签定此授权书，请提供以下签名：

Signature of Personal Representative Description of Authority

就诊人代表人签字_________________________ Date日期________________________
### PERSONAL MEDICAL HISTORY

**NEW STUDENTS ONLY**

This information is for the use of Health Services in providing necessary health care while you are a student at Hyde School. This side is to be filled out by student and/or parent/guardian. All questions must be answered. Comment on all "yes" answers below. 请解释以下所有的"是"选项。

这一面需要学生和/或家长/监护人填写。所有问题都需要回答。

<table>
<thead>
<tr>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>OCCUPATION</th>
<th>YEAR OF DEATH</th>
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</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
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<table>
<thead>
<tr>
<th>ALLERGIES</th>
<th>YES</th>
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</thead>
<tbody>
<tr>
<td>Penicillin</td>
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</tr>
<tr>
<td>Sulfa Drugs</td>
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<tr>
<td>Other meds (list)</td>
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<tr>
<td>Food (list)</td>
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</tr>
<tr>
<td>Bee Stings (Send ANKIT)</td>
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</tr>
<tr>
<td>Insect Bites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poison Oak or Ivy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay Fever</td>
<td></td>
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</tr>
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</table>

Describe any reactions:请描述反应症状

Date of last dental exam

<table>
<thead>
<tr>
<th>SURGERIES</th>
<th>YES</th>
<th>DATE</th>
<th>NO</th>
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<tbody>
<tr>
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<tr>
<td>Tonsillectomy</td>
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</tr>
<tr>
<td>Hernia Repair</td>
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<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS:注释

G:\health\center\forms\personal medical history
updated 5/13/2011
INFLUENZA VACCINE CONSENT
流感疫苗同意书

AND
以及

ADMINISTRATION RECORD
注射记录

Flu vaccines will be administered late October / early November (pending supply arrival). There will be a $10 charge applied to the student’s account to cover the cost of the vaccine.
流感疫苗将会在十月底十一月初注射（具体日期取决于疫苗供给到达时间）。$10将会从学生帐户扣除作为疫苗注射费用。

Influenza (flu) is a serious lung disease caused by a virus that spreads from person to person. Influenza can cause fever, headache, sore throat, chills, cough, muscle aches.
流行性感冒是由流感病毒传播的一种严重的肺部疾病。流感可以导致发烧，头痛，喉咙痛，发冷，咳嗽，以及肌肉疼痛。

Who should get the influenza vaccine? Any individual age 65 or older, adults and children with chronic illnesses, anyone whose immune system is compromised, health care workers, and anyone else who wants to decrease the chance of getting the flu.
谁应该接种流感疫苗？任何年龄超过65岁的老年人，有慢性疾病的成人以及儿童，任何免疫系统衰弱的人，健康护理工作者，和任何希望降低感染流感机会的人。

Who should NOT get the influenza vaccine? Anyone allergic to eggs, chicken feathers or dander, Gentamycin, Thimerosal, anyone sick with a fever, or anyone with a history of Guillain-Barre Syndrome. Anyone who has ever had a serious reaction to any vaccine in the past should also not receive the flu vaccine. If you are pregnant, you should consult with your physician or obstetrician about receiving the vaccine.
谁不应该接种流感疫苗？任何对鸡蛋，鸡毛或鸡皮屑，庆大霉素消毒液原料过敏的人，任何发烧的病人，或任何有病史的人。在过去曾对任何疫苗有剧烈反应的人也不应该接受流感疫苗。如果你怀孕了，你应该咨询你的医生或产科医师关于流感疫苗注射。

The vaccination will protect most people against most strains of influenza. The vaccine is updated yearly. It will begin to provide its protective effect after one to two weeks and will last for several months. Flu vaccines will not protect all persons who get them against influenza, but should at least decrease the severity of the illness.
流感疫苗将会保证大部分人不感染大多数流感菌种。该疫苗每年更新换代，并将在接种后一直两个星期内发挥效力。其有效期长达数月。流感疫苗并不能保证所有接种者都不得流感，但至少会降低感染的可能性。

I have read, or had explained to me, the above information, 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.
我已阅读，或已获悉，以上信息，并已有机会询问。我知道疫苗的好处与风险，并授权给于本人流感疫苗，或授权给以下学生流感疫苗。
Student Name: ______________________________ Date: __________________

Signature of Parent/Guardian: ______________________________ Relationship: __________________

FOR CLINIC/OFFICE USE

Hyde School
Name of Clinic

Manufacturer and Lot Number
Site of Injection

Chronic Disease

Signature of Vaccine Administrator Date
Part Two

The following pages are to be completed by a physician

以下部分由医生填写
### PHYSICAL EXAMINATION

#### HYDE SCHOOL

**616 High Street**

Bath, ME 04530

207-443-7186 Fax 207-443-7187

---

**Name of Student**

学生姓名

**Date of Birth**

出生日期

---

**Allergies**

过敏史

---

**Height**

身髙

**Weight**

体重

**B/P**

血压

**Respirations**

呼吸

**Pulse**

脉搏

---

- **Skin (皮肤)**: Tonsils (扁桃体)
- **Hair (毛发)**: Teeth (牙齿)
- **Nail (指甲)**: Gum (牙龈)
- **Eye (眼睛)**: Mouth (口腔)
- **Vision (视力)**: Tongue (舌头)
- **Ear (耳朵)**: Nose (鼻子)
- **EO (听力)**: Nodes (淋巴结)
- **Node (淋巴结)**: Spleen (脾)

#### Remarks on Abnormalities:

异常处备注

---

#### 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

---

#### Has this child had chickenpox? Date of illness

这个孩子曾患水痘吗？ 生病日期

---

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

有任何身体活动限制吗？ 必须注明限制期限？

---

#### IMMUNIZATION HISTORY

免疫史

<table>
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<tr>
<th>疫苗种类</th>
<th>1ST DOSE</th>
<th>2ND DOSE</th>
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<tr>
<td>RUBELLA</td>
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<td>Meningococcal?</td>
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<td>Varicella (disease or immunization)?</td>
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</table>

**Notes**

- PPD REQUIRED FOR FIRST YEAR ENTRANCE AT HYDE SCHOOL.
- 海德第一年学生必须提供接种PPD。

---

**Examiner's Name Typed or Printed:**

检查者姓名打印或正楷书写

---

**Telephone:**

电话

---

**Address:**

地址

---

**Fax:**

传真

---

**Date Signed:**

签名日期

---

(Please continue on back page.)

(请继续到下一页)

---

(updated 8/11/2009)
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
Physician’s Request for Medication Administration

处方药管理

学生姓名 student name________________________ 出身日期 Date of Birth________________________

医生姓名 Physician’s name________________________

医生（医院）地址 Physician’________________________

电话号码 Phone________________________ 传真号 Fax________________________

诊断 Diagnosis________________________

诊断日期 Date of Diagnosis________________________

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

学生必须从开药医生那里获得足够的关于用药，药效和副作用有关的指导信息。

• Medication 药名（包括用药剂量和次数）

________________________________________________

Everyday 每天 或 Academics Only 只在上学期间 This medication is optional 这种药不是必需的

• Medication 药名（包括用药剂量和次数）

________________________________________________

Everyday 每天 或 Academics Only 只在上学期间 This medication is optional 这种药不是必需的

• Medication 药名（包括用药剂量和次数）

________________________________________________

Everyday 每天 或 Academics Only 只在上学期间 This medication is optional 这种药不是必需的

最后一次就诊时间________________________ 下次复诊日期________________________
Physician's signature 医生签字  Date 日期
MAINE SCHOOL ASTHMA PLAN缅因学校哮喘规划
Maine Asthma Council (revised 7/15/2004)
ASTHMA PLAN INSTRUCTIONS哮喘规划指导

每个患有哮喘病的学生，从幼儿园到12年级，必须填写缅因学校哮喘规划并且由相关医生（或提供治疗者）签字，再由学校护士存档。这份表格同时必须有家长或监护人签字。这份规划必须每年更新，或在有重大的改变时进行更新（比如用药类型和剂量）。医生可以将此表传真给学校护士。此规划根据NHLBI哮喘指导而拟定。更多信息请联系学校护士或登录www.nhlbi.nih.gov).

Every student with asthma in grades kindergarten through twelve should have a current Maine School Asthma Plan completed and signed by their physician (or other health care provider) and kept on file in the school nurse’s office. The form must also be signed by a parent/guardian. The plan should be updated each year or when there are major changes to the plan (such as in medication type or dose). The physician’s office is encouraged to fax the plan to the student’s school nurse. The school plan is intended to strengthen the partnership of families, healthcare providers and the school. It is based on the NHLBI Guidelines for Asthma Management. (For more information contact the school nurse or www.nhlbi.nih.gov).

携带和使用快速缓解药和/或Epi-Pen
CARRYING AND ADMINISTERING QUICK RELIEF INHALERS and/or Epi-Pen:

- Most students are capable of carrying and using their quick relief inhaler by themselves. The student, student’s parents, school nurse and healthcare provider should make this decision. The school nurse must also evaluate technique for effective use.

- 大部分学生都有能力自己携带并使用吸入型药物。学生，学生家长，学校护士以及提供治疗者应一起就此作决定。学校护士必须就有效使用此药物的机器进行评估。

- The appropriate boxes must be checked by the parent, provider and school nurse to indicate the student’s ability to carry and self-administer these medications.

- 相对应的选项必须由家长，提供治疗者和学校护士就学生携带并自己使用这些药物的能力进行打勾选择。

USE OF QUICK RELIEF MEDICATIONS MORE THAN TWICE WEEKLY每周使用快速缓解药超过两次:

- This indicates poor control of asthma, and providers should be notified by the school nurse or designated staff.这意味着无法很好控制哮喘发生，学校护士或相关工作人员应该联系负责医生或提供治疗者
MAINE SCHOOL ASTHMA PLAN

Maine Asthma Council (revised 7/15/2004)

Child Name: __________________________ Date of Birth: __________________________

School: __________________ grade ________ Teacher: __________________________

School nurse: __________________ School phone: __________________ School fax: __________

TO BE COMPLETED BY PARENT OR GUARDIAN:

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse. 我授权同意医生和学校护士我子女有关哮喘病的医药信息

Parent or Guardian signature: __________________ Date: ______________

Parent or Guardian tel. # home: __________________

work: __________________ cell phone: __________________

Physician/Healthcare Provider Name: __________________

Parent concerns: __________________

My child may carry and use his/her: inhaled asthma medicine: □ Yes □ No Epi-Pen: □ Yes □ No □ N/A

My child may carry and use his/her: inhaled asthma medicine: □ is □否 Epi-Pen: □ is □ 否 □ N/A

TO BE COMPLETED BY STUDENT'S PHYSICIAN/HEALTHCARE PROVIDER:

Provider name: __________________

Tel. #: __________________ Fax #: __________________

□ NO changes from previous plan: 和之前的规划相比没有变化

Peak Flow:

Child's predicted, or personal best peak flow: __________________________

Date: ______________

Child's Green Zone: ________ Yellow Zone: ________ Red Zone: below ________

Medications:

Preventive (Controller) Medications: 预防（控制）药:

Quick Relief Medications: 快速缓解药: (check the appropriate quick relief med, circle device, list dose/ frequency):

□ Albuterol (Proventil, Ventolin) □ Pirbuterol (Maxair) □ Other: __________________________

Inhaler with spacer OR nebulizer □ Dose/Frequency: __________________________

Allergies: 过敏 / Triggers for asthma: 引起哮喘的原因: □ None known 原因不明

□ Avoid animals: 避免接触动物

□ Other triggers to avoid: 其它需要避免的隐患:

Exercise Pretreatment Instructions: 运动前的准备治疗: (check all that apply) 在符合情况处打勾