

# **HEALTH CENTER**

## **REGISTRATION PACKET**

### **For New Students**

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.

\_\_\_\_\_ ***Personal Medical History***

\_\_\_\_\_ ***Influenza Vaccine Consent***

\_\_\_\_\_ ***Midcoast Pediatrics Consent***

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

#### **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**

(Revised 3-4-08)

Student's Name \_\_\_\_\_  
Last First Middle Date of Birth Social Security Number

Home Address of Student \_\_\_\_\_  
Number and Street City State Zip

Student resides with (please circle): Father Mother Both Parents Other \_\_\_\_\_

1. Father's full name \_\_\_\_\_ Res. Phone ( ) \_\_\_\_\_

Street Address \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_

City, State & Zip \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

2. Mother's full name \_\_\_\_\_ Res. Phone ( ) \_\_\_\_\_

Street Address \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_

City, State & Zip \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

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

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_

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 \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of policy holder \_\_\_\_\_

Policy holder's employer \_\_\_\_\_

**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) and grant approval for Health Center personnel to receive diagnostic results from all providers. 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 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: \_\_\_\_\_

**MEDICATION AUTHORIZATION FORM**  
**Must be completed for all students.**

**Student Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent / Guardian Name:** \_\_\_\_\_

1) I have reviewed the enclosed **Hyde School Medication Policy** and give permission to the school nurse or designee to administer prescription and over the counter medications as ordered by my son's / daughter's physician or Hyde School's physician.

**Initials of Parent:** \_\_\_\_\_

2) I give permission for my son / daughter to have a **one** day supply of medication on his / her person (this is for sports and other off campus events).

**Initials of Parent:** \_\_\_\_\_

3) I give permission for my son/daughter to possess and self-administer emergency medication of an inhaled asthma medication or an epinephrine auto-injector.

**Initials of Parent:** \_\_\_\_\_

4) I am aware that students do not travel home with medications for vacations.

**Initials of Parent:** \_\_\_\_\_

5) Do you give permission for your child to travel home with all of his/her medications at the end of the school year and summer program? Yes  No   
(Parent must notify health center in writing of where to mail medication if permission not granted.)

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

**Initial of Student:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_

**PERSONAL MEDICAL HISTORY  
NEW STUDENTS ONLY**

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 side is to be filled out by student and/or parent/guardian. All questions must be answered. Comment on all "yes" answers below.

	AGE	STATE OF HEALTH	OCCUPATION	YEAR OF DEATH
Father				
Mother				
Brothers				
Sisters				

ALLERGIES	YES	NO
Penicillin		
Sulfa Drugs		
Other meds (list)		
Food (list)		
Bee Stings (Send ANKIT)		
Insect Bites		
Poison Oak or Ivy		
Hay Fever		

Describe any reactions:

Date of last dental exam \_\_\_\_\_

SURGERIES	YES	DATE	NO
Appendectomy			
Tonsillectomy			
Hernia Repair			
Other			

COMMENTS:

check if yes

STUDENT/FAMILY HISTORY	Student	Family Member
Anemia or Blood Disorder		
Arthritis		
Asthma, Hay Fever		
Chicken Pox		
Chronic Cough		
Dental or Gum Problems		
Diabetes		
Eatings Disorder (anorexia/bulemia)		
Eczema/Skin Problem		
Epilepsy, Convulsions		
Eye Problem		
Frequent Anxiety		
Frequent Bronchitis		
Frequent Depression		
Frequent Ear Infections		
Frequent Strep Throat		
Frequent Tonsillitis		
Frequent Urinary Tract Infection		
Gall Bladder Disorder		
Head injury w/ loss of consciousness		
Heart Disease		
High or Low Blood Pressure		
Insomnia		
Jaundice/Hepatitis		
Kidney Disease		
Migraines		
Mononucleosis		
Pain/Pressure in Chest		
Palpitations or Heart Murmur		
Recurrent Headache		
Rheumatic Fever		
Shortness of Breath		
Sinusitis		
Stomach/Intestinal Problems		
Thyroid Disorder		
Tobacco Use		
Tuberculosis		
Tumor/Cancer		
Ulcer		

**Female Students Only**

History of Pregnancy		
Severe Cramps		
Irregular Periods		
Excessive Flow		
Use of Birth Control		
Breast Disorder		
Other (Describe)		

**INFLUENZA VACCINE CONSENT  
AND  
ADMINISTRATION RECORD**

**Flu vaccines will be administered late October / early November (pending supply arrival). There will be a \$20 charge applied to the student's account to cover the cost of the vaccine.**

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.

**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.

**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 flue vaccine. If you are pregnant, you should consult with your physician or obstetrician about receiving the vaccine.

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.

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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.

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please Print)

Signature of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**FOR CLINIC/OFFICE USE**

Hyde School  
Name of Clinic

616 High Street, Bath, ME 04530  
Address

\_\_\_\_\_  
Manufacturer and Lot Number

\_\_\_\_\_  
Site of Injection

\_\_\_\_\_  
Chronic Disease

\_\_\_\_\_  
Signature of Vaccine Administrator

\_\_\_\_\_  
Date

**Midcoast Pediatrics, PA**  
**121 Medical Center Drive, Suite 2600**  
**Brunswick, ME 04011**

**David L. Enright, M.D.**  
**Amina B. Hanna, M.D.**

**Janice M. Wnek, M.D.**  
**Stephanie A. Phelps, 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

# **Part Two**

**The following pages  
are to be completed by  
a physician.**

Hyde School  
 616 High Street  
 Bath, ME 04530  
 207-443-7186 Fax 207-443-7187

**PHYSICAL EXAMINATION  
 IMMUNIZATIONS**

Hyde School  
 150 Route 169 PO Box 237  
 Woodstock, CT 06281  
 860-963-9096 Fax 860-963-1002

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_ Respirations \_\_\_\_\_ Pulse \_\_\_\_\_

key: 0 - normal + - abnormal ++ - treatment needed

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			

Remarks on Abnormalities:  
 \_\_\_\_\_

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

Any Chronic Illnesses:  
 \_\_\_\_\_

Has this child had chickenpox? Date of illness \_\_\_\_\_. If not, student will require vaccine. Note date(s) below.

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

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

**IMMUNIZATION HISTORY**

VACCINE TYPE	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
DTP							
TD							
POLIO							
HIB							
MEASLES							
MUMPS							
RUBELLA							
MMR							
HBV							
Meningococcal							
Varicella (disease or immunization?)							
<b>PPD-REQUIRED FOR FIRST YEAR ENTRANCE AT HYDE SCHOOL</b>							

Examiner's Name Typed or Printed: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address \_\_\_\_\_ Fax: \_\_\_\_\_

Signature \_\_\_\_\_ Date Signed: \_\_\_\_\_ Date of exam: \_\_\_\_\_

(PLEASE CONTINUE ON BACK PAGE...)

**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 \_\_\_\_\_

# MAINE SCHOOL ASTHMA PLAN

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Rm #: \_\_\_\_\_  
School Nurse: \_\_\_\_\_ School tel: \_\_\_\_\_ 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.

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

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

Provider name: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Fax# \_\_\_\_\_

NO changes from previous plan

### Peak Flow:

Child's predicted, or personal best peak flow: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Green Zone: \_\_\_\_\_ Yellow Zone: \_\_\_\_\_ Red Zone: below \_\_\_\_\_

### Medications:

Preventive (Controller) Medications: \_\_\_\_\_

Quick Relief Medications: (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 /Triggers for asthma:  None known

Avoid animals

Other triggers to avoid: \_\_\_\_\_

### Exercise Pretreatment Instructions (check all that apply)

Give 2 puffs of quick relief inhaler 15 minutes prior to recess/ physical education and/ or \_\_\_\_\_

May repeat 2 puffs of quick relief inhaler if symptoms recur with exercise, or \_\_\_\_\_

Measure Peak Flow prior to recess / physical education; restrict aerobic activity when child's peak flow is below \_\_\_\_\_

### Asthma Exacerbation Treatment Instructions:

➤ **YELLOW ZONE: If child is coughing, wheezing or short of breath, and/or peak flow is in Yellow Zone:**

Give 2 puffs of child's quick relief inhaler with spacer (or nebulizer treatment). May be repeated in 10 minutes if doesn't recover to Green Zone. Notify parents of exacerbation.

Other: \_\_\_\_\_

➤ **RED ZONE: If child is in respiratory distress, and/or peak flow is in Red Zone:**

Give 4 puffs quick relief inhaler (or nebulizer treatment), and call parent and Healthcare Provider.

**Call 911 if child does not improve quickly or parents/Healthcare Provider cannot be reached.**

Other: \_\_\_\_\_

### Special Instructions:

**Maine law now permits students to carry and use inhaled medications and Epi-pen after demonstrating appropriate use of Inhalers and or Epi-Pen to School nurse. Please check appropriate boxes below:**

➤ This student has the knowledge and skill to carry and use:  Inhaled medication  Epi-pen

➤ This student is not able to carry and use by himself/herself:  Inhaled medication  Epi-pen

➤ Please contact Healthcare Provider and parent if student is using quick relief medicines more than 2 times a week (i.e. in excess of pre-exercise treatment)

Other: \_\_\_\_\_

\_\_\_\_\_  
Healthcare Provider signature

\_\_\_\_\_  
Date

## TO BE COMPLETED BY SCHOOL NURSE: This student demonstrates knowledge and skill to carry and use:

Inhaler medications  YES  NO

Epi-Pen  YES  NO  N/A

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

# MAINE SCHOOL ASTHMA PLAN

## ASTHMA PLAN INSTRUCTIONS

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](http://www.nhlbi.nih.gov)).

### **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.
- 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.

### **USE OF QUICK RELIEF MEDICATIONS MORE THAN TWICE WEEKLY:**

- This indicates poor control of asthma, and providers should be notified by the school nurse or designated staff.

### **PEAK FLOW ZONES (based on student's personal or predicted best):**

#### **Green zone: Peak flow 80-100%**

- Symptoms and/or use of quick relief medication  $\leq 2$  times a week
- Use daily controller medication at home
- Full participation in physical education and sports

#### **Yellow zone: Peak flow 50-80%**

- Has symptoms or needs quick relief medication  $>2$  times a week
- Needs quick relief medication and further observation by school nurse; notify parents
- Attend physical education but restrict strenuous aerobic activity

#### **Red zone: Peak flow $<50\%$**

- Symptoms may include shortness of breath, retractions, difficulty talking or walking; quick relief medication not effective
- Requires immediate action, close monitoring and notification of parent and healthcare provider

## PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Fax # \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

\_\_\_\_\_

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

- Medication (including dosage and time to be administered)

\_\_\_\_\_

\_\_\_\_\_

Everyday **OR**  Academics Only  This medication is optional

- Medication (including dosage and time to be administered)

\_\_\_\_\_

\_\_\_\_\_

Everyday **OR**  Academics Only  This medication is optional

- Medication (including dosage and time to be administered)

\_\_\_\_\_

\_\_\_\_\_

Everyday **OR**  Academics Only  This medication is optional

Date of last M.D. visit \_\_\_\_\_ Follow up due \_\_\_\_\_

\*\*If lab work necessary, please attach script

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_