All attached paperwork for the upcoming summer sessions and / or school year must be completed and mailed into the health office at least one week prior to registration.

Physicals are required yearly. Students will not be allowed to participate in any sport / wilderness activity until a current physical is on file in the health office.

All forms to be returned for registration purposes are printed on white paper for your convenience. Please be sure that all forms are fully completed.

Registration Checklist

_____ Medical Emergency Consent Form. Please attach a copy of your current insurance card. (both sides)

_____ Student Health Calling Information Form (all students)

_____ Physical & Immunization Form (both sides)

_____ Personal Medical History Form (both sides)

_____ Medication Authorization Form (all students)

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

_____ Influenza Vaccine Consent (optional)
The school’s immunization policy is clear. It requires the exclusion of children who do not meet the requirements of the State of Connecticut law and its implementing rules.

1. PARENTAL RESPONSIBILITIES

a. To demonstrate proper immunization against each disease, a child shall present the school with a Certificate of Immunization from a physician, nurse or health official who has administered the immunizing agent(s) to the child. The certificate shall specify the immunizing agent, the dosage administered and the date(s) on which it was administered.

b. The following schedule lists the minimum requirements for immunizing agents administered to children entering school in the State of Connecticut.

- **4 doses of Polio** with at least one dose on or after the fourth birthday.
- **4 doses of DTP** vaccine with at least one dose on or after the fourth birthday
- **1 Td booster** within the last ten years
- **2 doses of MMR**
  - **Varicella** – proof of disease or immunization by 7th grade
  - **Hepatitis B Series** (3 Vaccines)

2. EXCEPTIONS

a. A 90 day grace period is a one-time provision for students who are transferring from out of state

b. A period of 21 days may be granted for students transferring within the state.

c. The parent (or child) presents to the school a physician’s written statement that immunization against one or more of the diseases may be medically inadvisable.

d. The parent states in writing an opposition to immunization because of a sincere religious belief. (must be notarized)
HYDE SCHOOL WOODSTOCK – MEDICATION POLICIES

PARENT / GUARDIAN RESPONSIBILITIES

1) The parent is responsible for obtaining all orders needed for medications and other supplement / vitamin needs.
2) The parent will refill all prescribed medication monthly and send directly to the Health Office to ensure an adequate supply at all times. **The Health Office gives reminder calls as a courtesy only – This should not be relied upon.** (Remember to send medication in original bottles that have been properly labeled)
3) The parent will keep an adequate supply of medication at home or place of destination for all vacation break times. The **Health Office does NOT send medications home during Fall, Winter, and Spring breaks.**

*Exception: Medications that are prescribed by our physicians and filled at our pharmacy will be sent home with students during break times.*

** ENTIRE SUPPLIES OF MEDICATION ARE SENT HOME WITH STUDENTS AT THE END OF THE SUMMER SESSION AND END OF THE SCHOOL YEAR WITH WRITTEN PARENTAL PERMISSION **

All medications remaining in the Health Office 2 weeks following school closing will be destroyed

STUDENT RESPONSIBILITIES

1) The student is to come to come to the Health Office for all prescribed medications at the proper times. They will come to the medication window with their water, state name, identify their medications, and take in the presence of the nurse. We DO NOT do mouth checks!
2) The student is to alert the Health Office immediately if there are any questions or concerns with regard to their medication.
3) The student is to notify the Health Office of any off campus events (sports, class trips, etc…) in which they will need medication packaged. If controlled medications are involved they must notify faculty to pick up their medication for them.
4) Students who are repeatedly reported to the Dean’s Area for medication delinquency will be reported to Administration for further action.
5) The student will not have any prescription or over-the-counter medication/supplements in his/her room, or on his/her person without health office authorization.

* The Health Office does not have storage available for medication not being utilized. These medications will be mailed home.
OVER THE COUNTER MEDICATION
All over the counter medications are subject to the following guidelines:
1) All OTC medications, (antacids, Tylenol, Ibuprofen, cough medicines, etc.) are supplied by Hyde School. Students are not allowed to keep any OTC medication, vitamins, and homeopathic supplements in their rooms. All supplemental vitamins/homeopathic medication must be accompanied by a Physician’s written order.
2) The Health Office has the authority to deny certain medications/homeopathic/herbal supplements. We do not allow any nicotine products on campus (Nicoderm, Nicorette, etc…)

PRESCRIPTION MEDICATION
All prescription medications are subject to the following guidelines:
1) Student will be evaluated by his/her prescribing physician at least once annually. (The school physician prescribes medication for acute illness, injury only. All maintenance, psychotropic, and stimulant type medications must be prescribed through your own physicians).
2) All students are to receive adequate instruction from their prescribing physicians regarding the self-administration, desired effect, and side effects of all medications.
3) A Physician’s Request for Medication Administration form must accompany all prescription medication. This form must clearly state the name of the student, medication, dosage, time of administration. All forms must be signed and dated by the prescribing physician.
4) All orders are to be renewed yearly or when there is a change in medication, dosage, or time of administration. (Orders expire in June of each year).
5) All medication will be sent directly to the Health Office in its original prescription bottle with the name of the student and medication on it. (The Health Office WILL NOT accept improperly labeled containers).

ABSOLUTLEY NO MEDICATIONS OR SUPPLEMENTS ARE ALLOWED IN STUDENT ROOMS WITHOUT HEALTH OFFICE AUTHORIZATION

DELINQUENCY IN TAKING MEDICATIONS
Although all medications have merit and should be taken consistently, we have found it necessary to divide medications into “essential” versus “non-essential” for reporting purposes only.

Medication utilized for the purpose of antidepressant, mood stabilizing effects as well as antibiotics being prescribed for acute illness are considered “essential”. Upon a weekly check those students who have been missing doses of “essential medications” will be reported to the Dean’s Area for disciplinary purposes. A medication delinquency note will also be sent home to the parent designated for medication purposes. This should enable parents to have regular conversations with their students regarding the responsibility of taking medications.

Medications utilized for the purpose of increased concentration (stimulant), allergies, and antibiotics prescribed for acne are considered “non-essential”. These medications are reviewed bi-monthly. They are not reported to the Dean’s Area. The parent designated for medication purposes will receive a medication delinquency note so that further use of these medications may be discussed between parent and student.
HEALTH OFFICE INFORMATION

HEALTH OFFICE HOURS:

The Health Office is open 7 days per week (1/2 day on Sunday) for medication and sick visits. Phone messages can be left at any time. (Calls will be returned ASAP.) There is on call emergency nursing coverage 24 hours per day, 7 days per week. During off hours, the nurse can be reached by faculty on duty.

Hyde School Health Office, 150 Rt. 169, P.O. Box 237, Woodstock CT. 06281
Phone # (860) 963 – 4731         Fax # (860) 963 – 4723

TRANSPORTATION (Health Appointments):

The school driver will provide transportation to area appointments for a fee of $20 per appointment. This fee is deducted from your student’s account through the business office. Driving services are usually available Monday – Friday from 7:30 AM to 4:00 PM. The school driver does not provide transportation to appointments 20 minutes or further from campus.

MEDICATION DISTRIBUTION FEE:

The school is charging a fee of $150 per trimester to all students that receive medication/vitamins/supplements on a daily basis (includes medication that is available daily, but only taken on an as needed basis). This is to defray the cost of medication storage, preparation, and administration. The Health Office will alert the business office each trimester and the money will be deducted from the student’s accounts.

MEDICATION:

Please review Hyde School Medication Policies. All policies were written with your child’s safety in mind and must be adhered to.

ROUTINE EXAMINATIONS:

Routine examinations, i.e. sports physicals, dental, eyes, & GYN should be made at home with your personal physicians. Most of these exams need to be made 4 - 6 weeks in advance, so please keep your child’s school schedule in mind so they can be seen during school breaks. Please understand that we have many students to care for and do not have the opportunity to schedule their routine exams. For emergency purposes, a list of specialists will be provided at your request.
SCHOOL PHYSICIAN:

We are pleased to announce that Dr. Joseph Alessandro of the Brooklyn Family Practice has been contracted as the Hyde School Woodstock physician for the coming year. The doctor will be coming to the school weekly (as needed) for appointments. He and his covering group are also available for telephone consultation 24 hours a day 7 days a week. In the event that your child may need to see the physician, they will be asked to contact you for parental permission. This is for insurance purposes. It will give parents the opportunity to make any prior phone calls needed to insure payment by your insurance company. It also gives the parents opportunity to contact the health office regarding any specific treatments the doctor may be ordering.

Brooklyn Family Practice, 63 Canterbury Rd., Brooklyn, CT. 06234
Phone # (860) 779-5940    Fax # (860) 779-5499

ORTHOPEDIC REFERRALS:

Orthopedic issues and sports/school injuries are initially reviewed by the Hyde School trainer. In the event that an orthopedic appointment is warranted, parents will be contacted. Again, this will give you the opportunity to review your insurance coverage and make necessary calls.

The Center for Bone and Joint Care
Orthopedic Associates of Windham County

35 Kennedy Drive, Putnam, CT. 06260
Phone # (860) 963-2133    Fax # (860) 963-8955

Dr. Scott A. Green
Dr. Kevin J. Reagan
Dr. Christian H. Dee
Dr. Biren V. Chokshi

PHARMACY: (Subject to change during the school year)

The school utilizes the Stop & Shop Pharmacy in Putnam, CT. The pharmacy has received a copy of all insurance information on file at the school. Every effort is made to utilize your insurance cards. Please keep in mind that not all insurances can be accessed through the pharmacy computer system. Any outstanding amounts are sent to the Hyde School business office and deducted from the student’s accounts. *If you have any questions regarding pharmacy billing, please contact them directly!* 

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

## GENERAL INFORMATION

*(This form MUST be filled out COMPLETELY)*

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and Street</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student resides with:</th>
<th>Both Parents</th>
<th>Father</th>
<th>Mother</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father’s full name</th>
<th>Res. Phone ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address if different than student’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s full name</th>
<th>Res. Phone ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address if different that student’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternate responsible person (not parent) to be reached in case of emergency if parent or guardian is unavailable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Phone ( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Medical Insurance Company</th>
<th>Phone ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address for insurance company</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-authorization required?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Drug Plan?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

*(Provide Copies of front and back of insurance cards)*

<table>
<thead>
<tr>
<th>Certificate/Policy numbers (include group number if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of policy holder</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address of policy holder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy holder’s employer</th>
<th>Policy holder’s D.O.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**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: __________________

---

*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 Woodstock – Health Office
Phone Number: (860) 963-4731  Fax Number: (860) 963-4723

Please return this completed form with your medical information. This will help facilitate information 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 # ___________________________       E-Mail ____________________
___ DO NOT leave message
___ Leave brief message, caller name and return #
   (Caller’s name, phone number, brief message)
___ May leave detailed message

Work Phone # ___________________________       Cell Phone # ________________
___ DO NOT leave message
___ Leave brief message
___ May leave 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:_________________________
PHYSICAL EXAMINATION

IMMUNIZATIONS

Name of Student

Date of Birth

Allergies

Date of Exam

Height

Weight

B/P

Respirations

Pulse

Skin

Tonsils

Thyroid

Kidneys

Hair

Teeth

Breast

Hernia

Nails

Gums

Lungs/Thorax

Genitalia

Eyes

Mouth

Heart

Rectum

Vision

Tongue

Abdomen

Back/Spine

Ears

Nose

Liver

Extremities

Hearing

Nodes

Spleen

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)

IMMUNIZATION HISTORY

PRIMARY IMMUNIZATION SERIES

<table>
<thead>
<tr>
<th>VACCINE TYPE</th>
<th>1ST DOSE MO/DAY/YR</th>
<th>2ND DOSE MO/DAY/YR</th>
<th>3RD DOSE MO/DAY/YR</th>
<th>4TH DOSE MO/DAY/YR</th>
<th>5TH DOSE MO/DAY/YR</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLIO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEASLES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUMPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUBELLA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARICELLA</td>
<td>Date of 2 vaccines</td>
<td>/</td>
<td>/</td>
<td>Date of disease</td>
<td>/</td>
</tr>
</tbody>
</table>

OTHER IMMUNIZATIONS

<table>
<thead>
<tr>
<th>DATE</th>
<th>VACCINE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MANTOUX TESTING REQUIRED FOR 1ST YEAR ENTRY TO HYDE SCHOOL

Examiner's Name Typed or Printed:

Telephone:

Address

Fax:

Signature

Date:

*** PLEASE COMPLETE PAGE 2 ON REVERSE SIDE ***
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  ________________
# PERSONAL MEDICAL HISTORY

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 or on reverse side.

## AGE STATE OF OCCUPATION YEAR OF DEATH

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Brothers</th>
<th>Sisters</th>
</tr>
</thead>
</table>

## STUDENT/FAMILY HISTORY YES NO RELATIONSHIP

<table>
<thead>
<tr>
<th>Anemia or Blood Disorder</th>
<th>Arthritis</th>
<th>Asthma, Hay Fever</th>
<th>Chronic Cough</th>
<th>Dental or Gum Problems</th>
<th>Diabetes</th>
<th>Eczema/Skin Problem</th>
<th>Epilepsy, Convulsions</th>
<th>Eye Problem</th>
<th>Frequent Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ALLERGIES YES NO

<table>
<thead>
<tr>
<th>Penicillin</th>
<th>Sulfa Drugs</th>
<th>Other meds (list)</th>
<th>Food (list)</th>
<th>Bee Stings (Send ANKIT)</th>
<th>Insect Bites</th>
<th>Poison Oak or Ivy</th>
<th>Hay Fever</th>
</tr>
</thead>
</table>

Describe any reactions:

## SURGERIES YES DATE NO

<table>
<thead>
<tr>
<th>Appendectomy</th>
<th>Tonsillectomy</th>
<th>Hernia Repair</th>
<th>Other</th>
</tr>
</thead>
</table>

Hearing Aids: No _____ Right _____ Left _____

Eye Glasses: Yes _____ No _____

Contacts: Yes _____ No _____

*Students that wear contacts MUST also have eye glasses in case of eye or contact problems*

Date of last dental exam: ____________

## COMMENTS: (Use reverse side if necessary)

<table>
<thead>
<tr>
<th>WOMEN ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Pregnancy</td>
</tr>
<tr>
<td>Severe Cramps</td>
</tr>
<tr>
<td>Irregular Periods</td>
</tr>
<tr>
<td>Excessive Flow</td>
</tr>
<tr>
<td>Breast Disorder</td>
</tr>
<tr>
<td>Other (Describe)</td>
</tr>
</tbody>
</table>
SKELETAL SYSTEM—Please check the appropriate box and indicate year and right or left if you have ever had any of these problems.

<table>
<thead>
<tr>
<th>Condition</th>
<th>KNEE</th>
<th>ANKLE, FOOT, TOES</th>
<th>LOWER LEG</th>
<th>ARM, WRIST, FINGER, HAND</th>
<th>HIPS, GROIN, THIGH</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprain/Strain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendinitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cartilage Problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated Kneecap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please use this area to describe any situations marked above

Have you had any illness or injury or been hospitalized other than already noted?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Have you received psychiatric treatment or counseling for a personality or character disorder, drug/alcohol abuse, eating disorder or an emotional problem?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Has your physical activity been restricted during the past five years?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Any history of back problems?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Recent change in health status of family member(s)?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

Date  
Student Signature

Date  
Parent/Guardian Signature
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:___________________________________

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:___________________________________

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:___________________________________

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

Student Signature:___________________________________
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

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:  _________________________________________________________________

- 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: ____________
INFLUENZA VACCINE CONSENT
AND
ADMINISTRATION RECORD

Flu vaccines will be administered in late October (pending supply arrival). There will be a 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 which spreads from person to person. Influenza can cause fever, headache, sore throat, chills, cough and 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 or 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.

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.

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 _______________

FOR CLINIC/OFFICE USE

Clinic Name:     Hyde School Health Office
Clinic Address:   150 Rt. 169     Woodstock, CT  06281
Date:          Allergies:
Temp:         Site of Injection:
Vaccine Manufacturer:  ____________________   Lot #:  _____________ Exp.:  _________
Signature of Vaccine Administrator: ____________________________    Title: ___________