

HYDE-WOODSTOCK HEALTH OFFICE REGISTRATION PACKET

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)

CERTIFICATE OF IMMUNIZATION STATE OF CONNECTICUT

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 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).**

ABSOLUTELY 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)

Student's Name _____
Last First Middle

Social Security Number _____ Date of Birth _____

Home Address _____
Number and Street City State Zip

Student resides with: Both Parents Father Mother Other

Father's full name _____ Res. Phone () _____

Address if different than student's _____ Bus. Phone () _____

Mother's full name _____ Res. Phone () _____

Address if different than student's _____ Bus. Phone () _____

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 _____

Address of policy holder _____

Policy holder's employer _____ Policy holder's D.O.B. _____

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 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 # _____

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: _____

Hyde School
 150 Route 169 PO Box 237
 Woodstock, CT 06281
 860-963-4731 Fax 860-963-4723

**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	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: ***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

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							
VARICELLA	Date of 2 vaccines	/ /	/ /	Date of disease	/ /	DATE	RESULTS
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

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 or on reverse side.

	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:

SURGERIES	YES	DATE	NO
Appendectomy			
Tonsillectomy			
Hernia Repair			
Other			

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)

STUDENT/FAMILY HISTORY	YES	NO	RELATIONSHIP
Anemia or Blood Disorder			
Arthritis			
Asthma, Hay Fever			
Chicken Pox			
Chronic Cough			
Dental or Gum Problems			
Diabetes			
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			
Tuberculosis			
Tumor/Cancer			
Ulcer			

WOMEN ONLY

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

SKELETAL SYSTEM-Please check the appropriate box and indicate year and right or left if you have ever had any of these problems.

	KNEE		ANKLE, FOOT, TOES		LOWER LEG		ARM, WRIST FINGER, HAND		HIPS, GROIN, THIGH		YEAR
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	
Fracture											
Sprain/Strain											
Tendinitis											
Dislocation											
Bursitis											
Surgery											
Swelling											
Locking											
Giving											
Cartilage Problem											
Dislocated Kneecap											
Other											

Please use this area to describe any situations marked above

	Yes	No
Have you had any illness or injury or been hospitalized other than already noted?		
Have you received psychiatric treatment or counseling for a personality or character disorder, drug/alcohol abuse, eating disorder or an emotional problem?		
Has your physical activity been restricted during the past five years?		
Any history of back problems?		
Recent change in health status of family member(s)?		

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.)

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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 _____ Total 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 _____ Total 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 _____ **Total 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 _____ **Total 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 _____ **Total 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: _____