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.
_____ Copy of 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)
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_______________________________________________________________________#1  Phone (         )_______________________

Address if different than student’s__________________________________________________________#2  Phone (        )_______________________

Mother’s full name_______________________________________________________________________#1  Phone (        )_______________________

Address if different that student’s___________________________________________________________#2  Phone (       )_______________________

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

Name__________________________________________________________________________________Phone (       )____________________________

Name of Medical Insurance Company________________________________________________________Phone  (       )__________________________

Address for insurance company___________________________________________________________________________________________________

Pre-authorization required?   Yes_____ No_____ Drug Plan?   Yes_____ No_____ (Provide Copies of front and back of insurance cards)

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

Name of policy holder________________________________________________________________ SSN_______________________________________

Address of policy holder_________________________________________________________________________________________________________

Policy holder’s employer_____________________________________________________________Policy holder’s D.OB._________________________

** Please attach copy of both sides of current insurance card **

Student’s known allergies:______________________________________________________________________________________________________

Last Tetanus Immunization:______________________________________________________________________________________________________

I hereby give consent for the Director of Health Services, School Nurse, Hyde School Faculty, or other health care providers considered appropriate by him/her to carry out accepted procedures for diagnosis, immunization, medical, dental, and minor surgical treatment, or counseling for my (son, daughter, ward). I also authorize the Health Services Department of Hyde School to share medical information (physical and/or mental health) with employees of Hyde School including, but not limited to, faculty, coaches, dorm parents and administration, for the purpose of coordinating and facilitating the overall well being of my (son, daughter, ward). This authorization will be in effect for a period of one year. I may revoke this authorization at any time by executing a written revocation addressed to the Hyde School Health Center. I am entitled to a copy of this authorization form and will request one if I desire to have one.

Parent/Guardian Name:___________________________________________________________________________Date:____________________

Signature:_________________________________________________________________________________Relationship:____________________

In rare instances a surgical emergency arises in which written consent by the parent or guardian is legally required. In this event and in order to avoid delay which might jeopardize the life or recovery of a student, we request the following permission from the parents or guardian, with the understanding that every effort will be made to contact the parents or guardian in case of any emergency. I hereby grant permission to the Director of Health Services, School Nurse or Hyde School Faculty to give consent for necessary anesthesia and emergency surgical procedures on my (son, daughter, ward).

Parent/Guardian Name:___________________________________________________________________________Date:____________________

Signature:_________________________________________________________________________________Relationship:____________________
Hyde School Woodstock – Health Office
Phone Number: (860) 963-4731   Fax Number: (860) 963-4723

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

**HIPPA STUDENT HEALTH CALLING INFORMATION**

Student Name: _______________________________
Date of Birth: ______________________________
Home Address:  ________________________________________________________

With whom do you allow us to share your child’s personal medical information with at your home?
Name:__________________________________ Relationship:___________________
Name:__________________________________ Relationship:___________________

Is there anyone that you do not wish to share it with at your home?
Name:__________________________________ Relationship:___________________
Name:__________________________________ Relationship:___________________

How may we contact you?

Home Phone # ___________________________       E-Mail ____________________
___ DO NOT leave message       ___ DO NOT leave message
___ Leave brief message, caller name and return #       ___ Leave brief message
   (Caller’s name, phone number, brief message)       ___ Detailed 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:_______________
The school's immunization policy is clear. It requires the exclusion of children who do not meet the requirements of the State of Connecticut laws.

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.

Polio - Minimum of 3 doses with **at least one dose on or after the fourth birthday**.

DTP (diphtheria, tetanus, pertussis) - Minimum of 4 doses with **at least one dose on or after the fourth birthday**. If series started after age 7 then only a total of 3 doses is needed.

Tdap - one single dose between the ages of 11-18

MMR – 2 doses separated by at least 28 days (1st dose on or after 1st birthday)

Varicella – 2 doses separated by at least 4 weeks for any unvaccinated student, or 2 doses separated by 3 months on or after the 1st birthday; or verification of disease

Hepatitis B Series (3 Vaccines) 1st and 2nd dose separated by at least 4 weeks, At least 16 weeks between 1st and 3rd dose.

Meningococcal Vaccine – 1 dose before entry into high school

*PPD / TB testing must be documented within 1 month prior to 1st year at Hyde School. If positive results – chest xray to rule out active disease.

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)
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)

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Student is at High Risk for TB due to geographic location or exposure          Y   /   N     (See below for testing results)____

Examiner's Name Typed or Printed:                                                                            Telephone:____ _________________

Address:                                                                                                                       Fax:___________________________

Signature:                                                                                                                     Date:__________________________

*** PLEASE COMPLETE PAGE 2 ***
Student’s Name: _________________________________

CARDIOVASCULAR HISTORY

1) Prior occurrence of exertional chest pain/discomfort or syncope/near syncope as well as excessive, unexpected, and unexplained shortness of breath or fatigue associated with exercise?

Yes_____ No_____ If yes, please explain:

2) Past detection of a heart murmur or increased blood pressure?

Yes_____ No_____ If yes, please explain:

3) Family history of premature death (sudden or otherwise), or significant disability from cardiovascular disease in close relative(s) younger than 50 years old, or specific knowledge of the occurrence of certain conditions (e.g. hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan’s syndrome, or clinically important arrhythmias)?

Yes_____ No_____ If yes, please explain:

CARDIOVASCULAR ASSESSMENT/TESTING

1) Auscultation to identify heart murmurs, especially any murmur suggestive of dynamic left ventricular outflow obstruction:

   Sitting ____________                    Standing ____________

2) Evaluation of femoral artery pulses to exclude coarctation of the aorta:

   Left ______________                     Right _______________

3) Identification of any physical signs of Marfan’s syndrome?

   Yes _____          No _____

4) If indicated:   EKG results: ______________________________

                   Echocardiogram results: ___________________

                   Other: ________________________________

______________________________________________              ________________
Examiner’s Signature                                                                        Date
PERSONAL MEDICAL HISTORY

Student’s Name ___________________________________________ Date ______________________

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

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

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

PERSONAL HISTORY:
List all allergies and reactions: ______________________________________________________________________
__________________________________________________________________________________________________

List all surgeries / hospitalizations and dates: ____________________________________________________________
__________________________________________________________________________________________________

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

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

Please check all that apply to student: ___________NO PROBLEMS

**Please use reverse side to explain all checked areas in detail. If faxing, be sure to include back side. **
MEDICATION AUTHORIZATION FORM
Must be completed for all students.

Student Name:__________________________________   Date:_________________

Parent / Guardian Name:_________________________________

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

Parent Signature:____________________________________(REQUIRED)

I give permission for my son / daughter to have a one day supply of medication on his / her person with the exception of controlled substances. (This is for sports and other off campus events).

Parent Signature:____________________________________

I give permission to the school nurse or designee to administer over the counter medication to my son / daughter as prescribed in the Standing Orders from the Hyde School physician.

Parent Signature:____________________________________(REQUIRED or Explain)

I give permission for my son / daughter to carry his / her emergency medication on his / her person. ___ Emergency Inhaler ___ Epi Pen ___ __________________ (other med.)

Parent Signature:____________________________________

I give permission for my son / daughter to travel home with all of his/her medications at the end of the school year.

Parent Signature:____________________________________
(Parent will notify health office in writing of where to mail medication if permission not granted.)

I have read the Hyde School Medication Policy in its entirety and agree to abide by its content.

Parent Signature:____________________________________(REQUIRED)

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

Student Signature:____________________________________(REQUIRED)
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:  _________________________________________________________________

Total

• 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:  _________________________________________________________________

Total

• 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: ____________
The Flu vaccine is **OPTIONAL**, but strongly recommended.

The Vaccine is NOT Available after November 1st, or when supply runs outs.

Flu vaccines will be administered in late September/October (pending supply arrival). There will be a charge applied to the student’s account to cover the cost of the vaccine.

Please read the attached Vaccine Information Statement Sheets

I have read the accompanying Vaccine Information Statement, 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: __________