THE TAFT SCHOOL
110 Woodbury Road Watertown, CT 06795
TEL: 860-945-7762 FAX: 860-945-7766

Health and Medical History Records

FORMS TO BE COMPLETED AND RETURNED BY JULY 15

Date: _____________ Returning ______ New ______ Summer School ______ Class ___________

Student's Name___________________________________ Date of Birth ________ Male____ Female____ Other____
First Last

Student's Address: ____
Street/Apt # City State Zip code Country

Student resides with Father_________ Mother______ If Divorced, Joint Custody? _______________Other_________

CONTACT INFORMATION:

Parent/Guardian Name: ____ Relationship _______________________

Telephone/Emailing You:

List in order of preference for being telephoned and check home (H) or work (W) or Cell

Name: ___________________________ Tel: ________________ H W Cell Relationship _______________________

Name: ___________________________ Tel: ________________ H W Cell Relationship _______________________

Name: ___________________________ Tel: ________________ H W Cell Relationship _______________________

Parent Email Address: ____

Student's Cell Phone Number ____

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

Name: ____ Relationship: _________________________

Address: ____ Telephone: __________________________

HIGHLY RECOMMENDED

I GIVE PERMISSION FOR MY CHILD TO RECEIVE THE INFLUENZA VACCINE IN THE FALL

Yes _________ No ________ Signature: ____ Date: ___________________

This information is strictly for the use of the health services in providing necessary health care while you are a student at The Taft School. In Loco Parentis: Due to the unique atmosphere of a boarding school, it may be necessary to discuss the health care of students with pertinent faculty members to assure that safe health care is provided and observed when a faculty member is acting in loco parentis.

Date: ______________________ Student's Name ______________________________

MEDICAL HISTORY [please indicate with dates):

1. Has student had any of the following? When?

Chicken Pox ___________________________________
Tuberculosis ___________________________________
Convulsions, Epilepsy ___________________________
Difficulty Exercising ____________________________
Malaria _______________________________________
Heart Disease __________________________________
Congenital Defect _______________________________
Gain/Loss of Weight _____________________________
Anxiety/Depression ______________________________
Chemical Dependency (drugs/alcohol] _______________
Learning Disabilities _____________________________
Muscular-skeletal disorder ______________________
Asthma _______________________________________
Diabetes _______________________________________
Fainting Attacks _______________________________
Headache/Concussion ___________________________
Speech/Hearing Difficulty _______________________
Kidney Disease _________________________________
Mononucleosis _________________________________
Tumor/Cancer/Cyst _____________________________
Eating Disorder (anorexia/bulimia) _______________
Orthodontics ___________________________________
Wear glasses or contact lenses (attach copy of prescription) ____________________________________

2. Surgical Intervention: ____

3. Serious Injuries/ Hospitalizations: ____

4. Allergy to Food and/or Insect: ____
Please describe type of food/insect and reactions

5. Allergy to Medication: ____
Name of medication and reaction

6. Emotional Stress ____

7. Menstrual Problem/Issues: ____

8. Psychiatric and/or Drug/Alcohol Treatment: ____

9. Other Chronic Illnesses: ____

List all medications that the student will be taking while at school. Please have your physician complete the medication authorization form(s).

Medication 1 _________________________________ Medication 2 _________________________________

Medication 3_________________________________ Medication 4_________________________________

THE TAFT SCHOOL
IMMUNIZATIONS AND LAB TESTING RECORD

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (M/D/YY)

MEDICAL NOTES (allergies, vaccine reactions, etc.)

	Vaccines	Date Given (m/d/yy)	Date Given (m/d/yy)	Date Given (m/d/yy)	Date Given (m/d/yy)	Date Given (m/d/yy)
Mandatory Immunizations	**Diphtheria, Tetanus, Pertussis** *5th dose after age 4 and before age 11*					
	Tdap booster (Td NOT acceptable) *1 dose required after age 11*					
	Polio (OPV/IPV)					
	MMR *2 doses required*					
	Varicella (chickenpox) *2 doses required*					
	Hepatitis B *3 doses required*					
	Meningococcal A (Menveo, Menactra) (MCV 4)					
Recommended Immunizations	**HIB** (HPV 4, HPV 2)					
	Pneumococcal (PCV 7, PCV 13, PCV 23)					
	Hepatitis A *2 doses required*					
	Human papillomavirus (HPV 4, HPV 2)					
	Influenza (most recent only)					
Other Immunizations	**Meningococcal B**					

Other Testing	**Hemoglobin**	**Date:**						
		Result:						
		Date:						
		Result:						
	TB testing (PPD/QuantiFERON)	**Date:**						
		Result:						
		Date:						
		Result:						

Student Name ____

SPECIAL INFORMATION

Family Medical History:

	Age	State of Health	Occupation
Father			
Mother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			

Has anyone in the student's immediate family died before age 50? If so, of what?

____

I give permission for the release of appropriate information from this medical information (including physician's physical) to the athletic trainer/coach for the maintenance of a healthy and safe environment while participating in the sports and extracurricular activities.

To the best of my knowledge, the above information given is complete and true: ____

*****Parent/Guardian's Signature Required**

Date: ____ ____

*****Student's Signature Required**

THE TAFT SCHOOL

STUDENT PHYSICAL EXAMINATION PRIOR TO ENTRY

Performed by a licensed MD, PA-C, or NP

PLEASE FILL IN ALL THE BLANKS, INCOMPLETE FORMS OR ONES NOT STANDARD FOR THE TAFT SCHOOL WILL BE RETURNED TO PARENT

Student's Name ____ _________ Date of Physical _____________________

Date of Birth ________________ Sex: Male ____ Female ____ Other _____ Allergies: ____________________________

Height _________ Weight _________ BMI ____________ Blood Pressure _______________ Pulse _________

Vision: Right 20/_________Corrected to 20/ ________________ Left 20/ ______________ Corrected to 20/ _______________

Corrected with Glasses _______________- Contacts: __________________

Examination of:	Normal	Abnormal	Comment on all "abnormal" answers
Head & Scalp			
Eyes (and fundi)			
Ears (and hearing)			
Nose			
Mouth & Teeth			
Pharynx			
Neck			
Thyroid			
Skin			
Lymph nodes			
Breasts			
Lungs			
Heart			
Abdomen			
Genitalia			
Extremities & Joints			
Spine			
Neurologic with Reflexes			
Emotional State			
Nutrition			

*******IS THIS STUDENT ABLE TO PARTICIPATE IN SPORTS WITHOUT RESTRICTIONS? YES ________ NO ______________**

Urinalysis: SG _____________ Sugar ___________ Albumin_____________ Cells ___________________________________

Hemoblobin/ Hematocrit _____________________

Has patient had BCG in the last 5 years? _____________

*NOTE: BCG is not a replacement for a PPD. All students must have a PPD or QuantifFERON TB Gold Blood test within the year prior to starting one's first year at Taft. There will be no exceptions to the requirement.

* Tuberculin test: Type_______________ Given on ___/___/___ Reactions (in mm) __________ Read on ___/___/____

OR

QuantiFERON TB Gold Blood test on ______________________ Results: ___________________________

If positive, CXR date: ___/___/___ Report (please include) ___________________ Treatment: _____________________

Recommendations: ____

MD/CLINCIAN SIGNATURE: ______________________________ **Address:** ____

NAME (printed): ____

MEDICAL, DENTAL, AND PSYCHIATRIC CONSENT FORM

I (we), parent(s) or legal guardian of ____________________________ Date of Birth ____________________
Student's Name

Who is a student at The Taft School, Watertown, CT, hereby authorize the Health Center staff at the school to administer to me/my child any medical/dental/psychiatric care, treatment, or medication deemed advisable by a physician licensed by the State of Connecticut or by any qualified health professional under the general supervision of a licensed physician. I (we) further consent to the immediate transfer of me/my child to any hospital or other medical facility or office in the event of an urgent or emergent medical, dental, or psychiatric condition, and authorize a representative of the school to consent on my behalf to any urgent or emergent medical, dental, or psychiatric treatment to be rendered to me/my child.

I further authorize any physician or health care provider who has rendered treatment to me/my child to release to the Health Center any and all medical records relating to or necessary for me/my child's treatment or diagnosis, in order to enable it to provide treatment for the physical and mental health of me/my child.

I authorize the school to release information to facilitate the medical, dental, psychiatric care of me/my child or as is necessary to enable the provider of care to complete a claim for health insurance. I understand and agree that I am exclusively responsible for the payment of all medical services rendered to me/my child.

In the event that I/my child does not have a health insurance recognized by the American and Connecticut Insurance system, I /we authorize the Taft School to acquire such insurance at a reasonable/ competitive price. This cost will be billed to me.

The school assures the parent(s) or legal guardian that all reasonable efforts to contact them will be made before exercising this authorization. This consent will remain in effect as long as I am/my child is a student at The Taft School.

Permission to give flu shot: Yes ___ No ___

Permission to give Required Immunizations: Yes ___ No ___

Allergies ______________________

Date of Most Recent Tetanus Booster ___________

Medications _______________

Chronic Major Illness: _______________________________

____________________________ ________________________________

Parent or guardian Signature Date

____________________________ ________________________________

Student Signature Date

Address: ____

Phone: Home ( )_______________ Cell ( ) ______________________Business ( ) ________________

STUDENT NAME ____

INSURANCE INFORMATION (2019-2020) (required)

Insurance Company ____

Insurance Co. Address: ____

Employer Providing Insurance ____

Primary Group # ______________________ Member ID # _____________________

Policy Holder ________________________ Date of Birth _____________________

Relationship to student _____________

Please provide a legible copy of insurance card front and back in the space below.

THE TAFT SCHOOL MEDICATION POLICY AND PHYSICIAN/DENTIST AUTHORIZATION FORM

Student's Name: ______________________ Date of Birth ______________ Diagnosis: ______________________

Parent/ Guardian's Signature: ______________________________________ Phone: ______________

Email of Parent/Guardian: ______________________________________

STUDENTS ARE NOT ALLOWED TO HAVE OVER-THE COUNTER OR PRESCRIPTION MEDICATIONS IN THEIR POSSESSION OR ADMINISTERED BY THE HEALTH CENTER UNLESS IN COMPLIANCE WITH THE FOLLOWING POLICY. VIOLATION OF THIS POLICY IS VIOLATION OF A MAJOR SCHOOL RULE. The interpretation of this policy and any adjustments to this policy are at the discretion of the Health Center.

Students are allowed to keep and self-administer only Health Center approved medications. Examples of such medications include but are not limited to allergy or asthma medications, insulin, birth control pills, topical or oral acne medications.

Certain medications are not allowed to be in the student's possession or self-administered by the student at any time. The Health Center is responsible for handling and administering these types of medications. Examples of such medications include but are not limited to: all controlled medications such as narcotics, stimulants anti-anxiety medications and sleeping medications; all psychotropic medications such as Zoloft, Celexa, Wellbutrin; and all cold/cough medications containing alcohol.

THE HEALTH CENTER WILL NOT ACCEPT PILLS OR MEDICATIONS BROUGHT TO US DIRECTLY BY THE STUDENT OR PARENT.

POLICY FOR SUBMISSION OF WRITTEN PRESCRIPTIONS

- Written prescriptions (hard copy) should be mailed to the Health Center within 2 weeks of registration. Do not send prescriptions directly to any pharmacy.
- For continuity, the Health Center will submit prescriptions to our local pharmacy, and medications will be delivered to the Health Center.
- The parent/guardian is responsible for providing the Health Center with an adequate supply of written prescriptions (up to 4 month supply) in advance.
- Parents/guardians need to keep a supply of medications at home for weekends, vacations, etc. as medications for off campus use will not be dispensed by the Health Center.
- Prescribing physicians and parent must complete this Authorization Form and submit it directly to the Health Center via mail, email, or fax.

PHYSICIAN/DENTIST AUTHORIZATION FORM FOR MEDICATIONS

Please note the above policy is not negotiable. Prescriptions are processed through the Health Center and the controlled substances are obtained from our local pharmacy ONLY. Students and/or parents/guardians are not allowed to bring medications from home. We are required to have a completed authorization form on file in order to administer the medications to this student. Each medication prescription needs separate, completed form. Should dosage of medication be changed, a new authorization form is required.

MEDICATION______________________ DOSAGE ______________ Administration Time ______________
*Please note, if a medication is ordered for the am, it will not be given after 12:00 noon.

Is the medication PRN? YES _______NO ______ Student is aware of side effects? YES ________ NO _________

ALLERGIES ______________________________________

Physician's Name (please print) ______________________ Phone ____________ Fax ______________

Physician' Signature ______________________ Date: ______________

Prescriptions can be mailed to: The Martin Health Center, 110 Woodbury Road, Watertown, Connecticut 06795

Parents of boarding students must complete the following form. <u>Please note</u> ALL medications will originate from the Health Complex Pharmacy. They will submit all claims to the insurance company and bill your credit card for the co-pay amount. It is your responsibility to update all Insurance changes immediately with the Health Complex Pharmacy. It is Health Complex's intentions to bill all eligible prescriptions to your insurance company. However, in the event that Health Complex does not have the current insurance information for billing, they will charge your credit card for the normal and customary prescription charge.

HEALTH COMPLEX PHARMACY

CHARGE ACCOUNT APPLICATION

Student's Name: ____ Birth date ___/___/____

Address ____Phone ________________________ Age ________ Sex ___________

City/State/Zip Code ____Email _______________________________

Student's Medication Allergies ____

Custodial Parent: Father _____ Mother ______ Both ______ Other ____

Father's Full Name ____ Res. Phone ________________________________

Bus. Phone ________________________________

Mother's Full Name ____ Res .Phone _________________________________

Bus. Phone _________________________________

Guardian's Full Name ____ Res. Phone _________________________________

Bus. Phone _________________________________

Name of Prescription Insurance Company ___________________________________ Phone # ___________________________ BIN#_____________________

ID# ____ Rx Group# ___________________________PCN#_____________________

Subscriber's Name: ____

Please return this application to the Taft Student Health Center prior to your child's arrival to the school. It will be forwarded to the Health Complex Pharmacy. Be sure to attach a copy of your prescription plan card, both sides, enlarged, readable.

****Expiration date must be valid for the entire year. If not listed or date expired, the pharmacy cannot process the charges.

PLEASE NOTIFY US OF NEW CARD NUMBERS AND EXPIRATION DATES.

Co-pay charges: A valid credit card and expiration date must be given.

(Circle One) Master Card Visa American Express Discover

Credit Card # ____ Expiration Date ________________ V-Code _________________

Name on Card ____ Billing Address ____

I hereby give my permission to charge the above credit card for the co-pay or normal and customary amount of my child's prescriptions.

Signed ____

Send changes of insurance to: Health Complex Pharmacy and Medical Supply, 35 Deforest Street, Watertown, CT 06795

Telephone # (860) 274-8816 Fax # (860) 9451728

The Taft School Martin Health Center

Important Information Regarding Concussions

A recently enacted Connecticut law now requires us to provide you with important information regarding concussions, particularly sport participation and the risk of concussions. The law was enacted as a means to reduce the number of concussions in children. It requires us to provide parents with written information regarding concussions and the treatment of concussions at Taft. The law also requires all parents to sign an informed consent authorizing their child to participate in school athletics at Taft.

We at The Taft School Martin Health Center also feel strongly that we have a responsibility to educate our students be they athletes or otherwise and their parents about the signs and symptoms of mild traumatic brain injuries; otherwise known as concussions. Although concussions can occur on the sports field, they can also occur off the field. The Martin Health Center staff and The Taft School athletic trainers are trained to recognize those that may demonstrate concussive-type symptoms. However, many concussions can go unreported, causing permanent effects.

What is a concussion?

A concussion is the most common type of brain injury. It is the result of a direct blow to the head or body causing the head and brain to move quickly back and forth. This injury typically results in impairment of neurological function. The brain ceases to function normally and may result in the signs and symptoms listed below. A concussion can affect one's ability to perform everyday activities and affect reaction time, balance, sleep, and classroom performance. You cannot see a concussion. You might notice some of the symptoms right away, or symptoms can show up hours or days after the injury.

Symptoms of a concussion.

It is important to understand the signs and symptoms listed below are common for a concussion. A person with a concussion may exhibit **some or all** of the symptoms listed below:

Headache
Neck Pain
Nausea
Vomiting
Loss of appetite
Balance Problems/Dizziness
Drowsiness/Fatigue
Difficulty Sleeping
Nervousness/Anxiety
Sensitivity to light/noise
Continued Blurred or Double Vision
Altered Emotions/Inappropriate Behavior
Ringing in the ears
Feeling slowed down
Feeling in a "fog"
Difficulty concentrating or remembering
Confusion/Disorientation/Irritability
Incoherent/Slurred Speech
Loss of Consciousness

Prevention of a Concussion.

Participation in many activities may result in a head injury or concussion. Although helpful, helmets, face shields, mouth guards and other protective equipment do not eliminate the risk of concussions. Purposeful or flagrant head contact is not safe and not permitted in any Taft sport or activity.

Treatment of a Concussion.

Following a concussion, the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play and other activities before all your symptoms resolve. In rare cases, repeat concussions can cause permanent brain damage, and even death. It is imperative that those students who suspect they may be suffering from a concussion report it to a Taft athletic trainer, the Taft physician, a nurse at the Martin Health Center, a Taft teacher, or Taft coach immediately.

The Taft School has a specific protocol it follows with respect to any student who is suspected of suffering a concussion. This protocol includes being removed from activities and the classroom until cleared to return by Dr. Fountas, our school physician. Parents, teachers, the class dean and dorm parent(s) all are notified of the injury. Depending on the severity of the injury, an injured student might remain in the health center, be sent home for better rest, or referred to the hospital/other medical providers for further diagnostic tests and treatment. If a student remains at school, their condition will be regularly monitored by Dr. Fountas and the Health Center.

When appropriate, the athletic trainers will begin a Return to Play program ("RTP"). This is a progressive exercise program that prepares the student to return to their prior level of activity. To advance in the program the student must remain symptom free for each stage. The athletic trainers monitor the student while they progress through the program and Dr. Fountas receives daily updates as to the student's reaction to the increase in their physical activity level. Once the student has completed the program, the student is referred back to Dr. Fountas for her final evaluation to clear the student to return to activity. Parents also must consent in writing to their child's return to play as per the new Connecticut law. No student will be allowed to return to any extracurricular activity without completing this protocol. No student will be allowed to return to a game/scrimmage on their first day back to play.

Second Impact Syndrome

The majority of athletic head injuries are minor and the symptoms typically resolve in 7-10 days. In rare cases, repeat concussions can occur and can cause permanent brain damage, or even death. Following a concussion, the brain needs time to heal. A person is more likely to have a repeat concussion if he or she returns to play and activities before all the symptoms resolve. This is referred to as *Second Impact Syndrome*. The symptoms of a second concussion will be greater and last longer. Even a minor hit to the

head can bring this syndrome on if the initial concussion has not resolved itself. This is why it is critical that students adhere to the RTP protocol.

Additional Information.

To learn more about concussions please go to: www. concussionwise.com.
This site offers a free online interactive course on concussions for coaches, parents and students. Please also feel free to contact Dr. Fountas, the School's physician, or Sergio Guerrera, the School's head athletic trainer, to obtain more information about concussions and the School's treatment of concussions.

_______________________________	_______________________________
Diane Fountas, M.D.	Sergio Guerrera, Head Athletic Trainer

The Taft School
Student Participation Agreement, Assumption of Risk and Release Regarding Concussions

Printed Name of Student: __________________________________

By signing below, both the student and the student's parents, on behalf of their minor child, fully understand and agree that:

- we have read and understood the information regarding concussions contained in ***The Taft School's Important Information Regarding Concussions***. We understand the severities associated with concussions and the need for immediate treatment of such injuries.

- in consideration, and as a condition of The Taft School permitting my participation (or my child's participation) in a Taft School athletic team and other activities, which include but are not limited to training, trying out, practicing, playing and traveling, we freely acknowledge that we are aware of, and accept, the risks of concussions associated with such participation.

- my participation (or my child's participation) in such athletic team and other activities is wholly voluntary and not required in any way by The Taft School. I, or my child, is free to elect to participate in another sport or activity at Taft.

- we fully realize the dangers of participating in such sport and activities and fully assume the risks associated with such participation, which may include, but are not limited to, the possibility of serious physical and/or mental trauma or injury, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment, and which may be caused in whole or in part by numerous factors, including my (or my child's) medical or physical condition, the actions or inactions of other athletes and students, the conditions of the premises, and the negligence of Taft School or individuals released below.

- as a student (or parents of a Taft student), I/we understand it is our responsibility to report all injuries and illnesses to a Taft School Martin Health Center and/or the athletic trainers.

- we each know and understand that we should notify the proper athletic trainer and/or Martin Health Center if I think I may have sustained a concussion, or if the parent(s) think their child may have sustained a concussion.

- **Waiver and Release from Liability. By signing below, the student and the student's parents, on behalf of their minor child and for themselves, and for the respective heirs, executors, administrators, representatives, successors and assigns of the student and the parents hereby waive, release, acquit, discharge and agree to hold harmless The Taft School, its officers, trustees,**

employees, agents and representatives under the direction and control of The Taft School, from any and all claims for liability, damage, injury or loss of any description that I, or my child, may have or which may hereafter accrue to me, or my child, in connection with my participation, or my child's participation, in activities at The Taft School, including those activities associated with participation in a Taft School athletic team.

- This **Waiver and Release from Liability** ***shall not*** apply if (1) the liability, loss or injury is caused solely by the gross negligence of The Taft School, its officers, trustees, employees, or agents; that is, no negligence or any other act or omission by any other person or entity (including the student or his/her parent, or a third party) contributes to any extent to the liability, damage, injury or loss, or (2) the liability, damage, loss or injury is caused by the **intentional misconduct** of The Taft School, its officers, trustees, employees or agents.

The student and parents signing below have read ***The Taft School's Important Information Regarding Concussions*** and ***The Taft School Participation Agreement, Assumption of Risk and Release Regarding Concussions*** and fully understand the information contained in these documents and their terms. They further understand that by signing this ***Taft School Student Participation Agreement, Assumption of Risk and Release Regarding Concussions*** the student is, and the parents are, on behalf of their minor child and for themselves, giving up substantial legal rights. They have not been induced to sign this Agreement by any promise or representation and sign it voluntarily and of their own free will.

Printed Name of Student: ______________________________

____ Date:_____________

Student Signature

____ Date:_____________

Parent or Legal Guardian Signature

____ Date:_____________

Parent or Legal Guardian Signature