HOTCHKISS
Summer Portals

Email: summer@hotchkiss.org
Mail to: The Hotchkiss School, Summer Portals
11 Interlaken Rd. Lakeville CT 06039

Summer Portals Program(s): _____

Student Name: _____ Resides with Parent One: Yes / No
Date of Birth: _____ Resides with Parent Two: Yes / No
Height: _____ Weight: _____ Age: _____ Other _____

Parent One Name: _____ Email: _____
Best Phone: home/cell _____ Second Phone: home/cell_____

Parent Two Name: _____ Email: _____
Best Phone: home/cell _____ Second Phone: home/cell_____

Emergency/illness Contact Name and Relationship: _____
Best Phone: home/cell _____ Second Phone: home/cell_____
Email: _____

If your child is a non-US resident, you must select the comprehensive insurance plan offered.

If you have US resident health insurance for your child, please list:

_____
INSURANCE COMPANY NAME **POLICY NUMBER & PHONE NUMBER**

_____
INSURANCE COMPANY ADDRESS **CITY, STATE & ZIP CODE**

PLEASE ENCLOSE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD.

PERMISSION FOR MEDICAL CARE

I, the legal parent or guardian of _____, understand that in the event of a medical emergency no informed consent is required for my child's treatment and that emergency medical care will be obtained and rendered to my child. I further understand that if my child's medical condition is urgent but not life threatening, informed consent is required for treatment. If such a situation occurs and reasonable attempts to reach me for consultation and informed consent are unsuccessful, then I hereby delegate to the Medical Director of The Hotchkiss School or his/her designee or representative the authority to make on my behalf all medical decisions regarding the care and treatment of my child, including decisions on surgery and the administration of anesthetic, and to give informed consent to such treatment.

I also consent to, and authorize the Medical Director of The Hotchkiss School, his designee, and other School medical personnel to provide care and treatment (including administering medications and antibiotics) for my child's routine health needs or conditions, such as colds, ordinary infections and minor injuries. I understand and agree that further specific consent will not be obtained at the time the routine care and treatment are provided and that the School will not notify me unless the Medical Director deems it appropriate or necessary.

_____ _____
Date Parent or Guardian Signature

MEDICAL HISTORY TO BE COMPLETED BY <u>PARENT/GUARDIAN</u>

STUDENT NAME: _____ Date of Birth: _____

Does your student have any allergies (include medications, insect stings, environmental, or food type)? ❒ YES ❒ NO

If yes, please specify allergy and describe severity_____

_____

Does your student require an Epi-pen or Auvi-Q? ❒ YES ❒ NO

Does your student take any regular medications (include birth control, vitamins, supplements, etc.)? ❒ YES ❒ NO

If yes, please specify medication and dose _____

_____

Has your student had any surgeries or hospitalizations? ❒ YES ❒ NO

If yes, please list reason and the date_____

_____

Has your student ever been diagnosed with any of the following? Please provide details below.

- ❒ ADD/ADHD
- ❒ Alcohol or Drug Dependency
- ❒ Anemia or other Blood Disease
- ❒ Anxiety
- ❒ Asthma
- ❒ Bipolar Disorder
- ❒ Blood Clots
- ❒ Bone Problems or Fractures
- ❒ Cancer
- ❒ Concussion or Head Injury
- ❒ Depression
- ❒ Diabetes
- ❒ Eating Disorder
- ❒ Gastrointestinal or Digestive Problems
- ❒ Gynecologic Problems
- ❒ Headaches/Migraines
- ❒ Heart Problem or Murmur
- ❒ High Blood Pressure
- ❒ Kidney Problems
- ❒ Liver Problems
- ❒ Lung Problems (other than asthma)
- ❒ Rheumatologic Disease
- ❒ Seizures
- ❒ Sexually Transmitted Infection
- ❒ Skin Problems (eg. acne or eczema)
- ❒ Thyroid or other Endocrine Problems
- ❒ Tuberculosis
- ❒ Urinary Tract Infections
- ❒ Other:_____
- ❒ NONE

_____

_____

_____

_____

Family History

Have any of your student's family members experienced sudden death at less than 55 years of age? ❒ YES ❒ NO

If yes, please provide details_____

Please provide any other relevant family history

_____

_____

Completed by: _____ Date: _____

THE HOTCHKISS SCHOOL – SUMMER PORTALS
REQUIRED STUDENT HEALTH EXAM
TO BE COMPLETED BY HEALTH CARE PROVIDER

STUDENT NAME: _____DATE OF BIRTH: _____

PHYSICAL EXAMINATION BY HEALTH CARE PROVIDER REQUIRED:

BP:_____ P:_____ Height:_____ Weight:_____

Eyes:_____ Lungs:_____
Ears:_____ Abdomen:_____
Nose and Throat:_____ Genitalia:_____
Teeth:_____ Extremities:_____
Skin:_____
Lymph Nodes:_____ **LABS**
Heart:_____ Urinalysis:_____
Murmurs:_____ Hemoglobin or Hematocrit:_____
Enlargement:_____

Allergies to medications:_____
Other allergies – please describe:_____
Epi-pen or Auvi-Q required ❑ YES ❑ NO
Explain:_____

Please list any medications and dosages:_____
_____
_____

Permission to Administer Medications form must be completed for all prescription medications. *For compliance with safety standards,* ***all medication that is required to be stored in the Health Center, including, but not limited to controlled narcotics, stimulant medications, and psychotropic medications, must be in pre-packaged individual dose packets*** *as Health Center staff are not permitted to repackage medication.* The Salisbury Pharmacy provides Medicine on Time, individual dose packaging, and delivers medications to campus on a daily basis, Monday through Friday. Families must register with the pharmacy at http://schools.spgrx.com for prescriptions to be filled and pharmacy staff can also be reached at 860-435-9388 with any questions.

Please provide details of (1) psychiatric care or treatment, (2) fractures, (3) surgeries, (4) concussions, (5) any other problems beyond routine childhood illnesses.

_____
_____
_____

Is this student capable of physical activity and participation in a competitive athletic program? ❑ YES ❑ NO
Please advise if there are any restrictions, conditions, or injuries._____
_____

Name of Examiner:_____

Signature of Examiner:_____Date:_____

Address:_____Telephone:_____

e-mail:_____Fax:_____

The Hotchkiss School Immunization Record

Name of Student:_____ Date of Birth:_____

The following immunizations are **REQUIRED by The State of Connecticut and The Hotchkiss School**. This form must be completed by a Physician, PA or APRN.

DATE EACH DOSE IS GIVEN (month/day/year)

REQUIRED VACCINES	1st Mo/Day/Yr	2nd Mo/Day/Yr	3rd Mo/Day/Yr	4th Mo/Day/Yr	5th Mo/Day/Yr
Polio – At least 3 doses required. The last dose must be on or after the 4th birthday.					
DTaP - At least 3 doses required, one of which should be Tdap.					
Tdap – Required					
***MMR –** 2 doses required. 1st dose must be on or after the 1st birthday and the 2nd dose must be at least 28 days after the 1st dose. *If a student has a history of measles, mumps, or rubella it must be confirmed in writing by specific blood testing.*					
***Varicella** – 2 doses required or verification of disease. 1st dose must be on or after the 1st birthday. Minimum interval between doses: 3 months if person was younger than age 13 years, 4 weeks if person was age 13 years or older.			Verification of Chicken Pox Disease by MD, PA, APRN, or lab confirmation:		
Meningococcal – 1st dose required at age 11-12 years and a 2nd dose at age 16 years. If the 1st dose is given at 13-15 years, the 2nd dose should be at 16-18 years with at least 8 weeks between doses. If the 1st dose is given after the 16th birthday, a second dose is not required.					
Hepatitis B – 3 doses required. At least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; 16 weeks between doses 1 and 3. Dose 3 should not be given before 24 weeks of age.					

*If MMR and Varicella are not administered on the same day, they must be separated by at least 28 days.

Optional Vaccines	DATES GIVEN
Hepatitis A	
Hemophilus (Hib)	
HPV (highly recommended)	
Meningitis B (recommended)	
Typhoid	
Yellow Fever	
OTHER	

Signature of Physician/PA/APRN:_____Date:_____

The Hotchkiss School
Mandatory Tuberculosis (TB) Risk Assessment Form
PHYSICIAN/PA/APRN Signature Required

Section A

1. Was the student born in a country with an elevated TB rate? Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.	☐ Yes	☐ No
2. Has the student traveled to or resided for at least 1 month in a country with an elevated TB rate? Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.	☐ Yes	☐ No
3. Is the student immunosuppressed, currently or planned? HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication.	☐ Yes	☐ No
4. Has the student had close contact with anyone with known active TB disease?	☐ Yes	☐ No

If the answer is "No" to all of the above questions, skip Section B and sign at the bottom of this page.
If the answer is "Yes" to ANY of the above questions, Section B must be completed and sign at the bottom of this page.

TB Testing Indicated

Section B:

Any student identified to be in a high-risk group must be tested for TB with either a skin test (PPD) or IGRA (Quantiferon Gold Assay). Testing must be completed within one year prior to admittance.

Has the student received the BCG vaccine?	☐ Yes	☐ No

History of BCG vaccination does not eliminate the need for testing a member of a high-risk group. An IGRA (Quantiferon Gold Assay) is the preferred method of testing if the student received BCG. If you choose to complete a PPD as the initial test for a student who has received BCG vaccination, a positive PPD result with a negative chest x-ray will require further testing with the IGRA to determine if the PPD result is from the vaccine or latent TB infection.

PPD	Date Placed:	Date Read:	Result in mm = _____mm

IGRA – Quantiferon Gold Assay	Date:	Result: ☐ Negative ☐ Positive ☐ Indeterminate

If either the PPD or IGRA (Quantiferon Gold Assay) is positive, a chest x-ray is required.

Chest x-ray	Date:	Result:

Please note, a chest x-ray alone is not sufficient screening as a PPD or IGRA (Quantiferon Gold Assay) is required to screen for latent tuberculosis.

Has the student been previously treated for latent or active TB infection?	☐ Yes	☐ No	If yes, please provide details:

Student Name: _____ Date of Birth: _____

Parent Name/Signature:_____ Date: _____

Physician/PA/APRN Name/Signature:_____ Date: _____

The Hotchkiss School Health Center
11 Interlaken Road, Lakeville, CT 06039
Telephone: (860)435-3226 Fax: (860)435-2422

Permission to Administer Medications

Student Name: _____Date of Birth: _____

Allergies: _____

MEDICATION and STRENGTH	DOSAGE (e.g. 2 tabs)	ROUTE	FREQUENCY	ADDITIONAL INSTRUCTIONS	REASON FOR TAKING	START DATE	STOP DATE
1.							
2.							
3.							
4.							
5.							

For compliance with safety standards, ***all medication that is required to be stored in the Health Center, including, but not limited to controlled narcotics, stimulant medications, and psychotropic medications, must be in pre-packaged individual dose packets*** *as Health Center staff are not permitted to repackage medication.* The Salisbury Pharmacy provides Medicine on Time, individual dose packaging, and delivers medications to campus on a daily basis, Monday through Friday. Families must register with the pharmacy at http://schools.spgrx.com for prescriptions to be filled and pharmacy staff can also be reached at 860-435-9388 with any questions.

PRESCRIBER NAME: _____ PHONE: _____ FAX: _____

PRESCRIBER SIGNATURE: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____