

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 PARENT/GUARDIAN**

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.

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

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### **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

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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: \_\_\_\_\_

Heart: \_\_\_\_\_

Murmurs: \_\_\_\_\_

Enlargement: \_\_\_\_\_

**LABS**

Urinalysis: \_\_\_\_\_

Hemoglobin or Hematocrit: \_\_\_\_\_

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)

<b>REQUIRED VACCINES</b>	<b>1<sup>st</sup></b> Mo/Day/Yr	<b>2<sup>nd</sup></b> Mo/Day/Yr	<b>3<sup>rd</sup></b> Mo/Day/Yr	<b>4<sup>th</sup></b> Mo/Day/Yr	<b>5<sup>th</sup></b> Mo/Day/Yr
<b>Polio</b> – At least 3 doses required. The last dose must be on or after the 4 <sup>th</sup> birthday.					
<b>DTaP</b> - At least 3 doses required, one of which should be Tdap.					
<b>Tdap</b> – Required					
<b>*MMR</b> – 2 doses required. 1 <sup>st</sup> dose must be on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be at least 28 days after the 1 <sup>st</sup> dose. <i>If a student has a history of measles, mumps, or rubella it must be confirmed in writing by specific blood testing.</i>					
<b>*Varicella</b> – 2 doses required or verification of disease. 1 <sup>st</sup> dose must be on or after the 1 <sup>st</sup> 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:		
<b>Meningococcal</b> – 1 <sup>st</sup> dose required at age 11-12 years and a 2 <sup>nd</sup> dose at age 16 years. If the 1 <sup>st</sup> dose is given at 13-15 years, the 2 <sup>nd</sup> dose should be at 16-18 years with at least 8 weeks between doses. If the 1 <sup>st</sup> dose is given after the 16 <sup>th</sup> birthday, a second dose is not required.					
<b>Hepatitis B</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.

<b>Optional Vaccines</b>	<b>DATES GIVEN</b>
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.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is the student immunosuppressed, currently or planned? HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids (equivalent of prednisone $\geq 15$ mg/day for $\geq 1$ month) or other immunosuppressive medication.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has the student had close contact with anyone with known active TB disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate	

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

Chest x-ray	Date:	Result:
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*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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please provide details:
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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:** \_\_\_\_\_