HOTCHKISS
Summer Portals

Returning Student Health Form

Please complete and return this form to the Summer Portals office.
Email: summer@hotchkiss.org Mail to: The Hotchkiss School, Summer Portals 11 Interlaken Rd. Lakeville CT 06039

Student Name: _____ Date of Birth: _____Age:_____
Summer Portals Program(s): _____Year attended: _____

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: _____

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

To be completed by Parent: Please list any injuries or illnesses your child has or had during the past year. Please note that the school requires parents to notify the Health Center of all medications.

Allergies & reaction: _____
Epi-pen or Auvi-Q required: _____YES _____NO

Specific dietary needs:_____
Medications:_____
Physical/Sport Restrictions:_____

Please attach official record of any recent vaccinations with dates administered.

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.

Parent 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: _____