Here’s what’s included in the Returning Student’s Health Packet:

- Parent Cover Letter
- Special Notice
- Health Record Form (3 pages)
- Physical Exam Form
- Health Insurance Verification Form (Domestic Students Only)
- Walgreens Form
- Massachusetts Immunization Information Fact Sheet (2 pages)
- Medication Form
June 2020

Dear Parents,

As we finish this school year, plans are already underway for the upcoming 2020/2021 year.

**FORMS INCLUDED IN THIS ELECTRONIC PACKET FOR ALL STUDENTS ARE:**

- **Special Notice** with important updated information
- **St. Mark’s Health Record Form** COMPLETE AND RETURN IMMEDIATELY
- **Physical Exam Form** RETURN BY EMAIL AFTER CURRENT EXAM* IS COMPLETED
- **Medication Order Form** REQUIRED FOR ALL PRESCRIPTION MEDICATIONS ONLY
  - please make additional copies for each medication
- **Health Insurance Verification Form** COMPLETE AND RETURN IMMEDIATELY (Domestic Students Only)
  - please include a copy of front and back Insurance Cards

**IN ADDITION, NEW STUDENTS RECEIVE:**

- **Authorization For Use/Disclosure of Health Information** RETURN IMMEDIATELY
- **Transportation Permission to Planned Parenthood** RETURN IMMEDIATELY
- **Meningococcal Disease/Vaccine/Waiver Form** RETURN IMMEDIATELY IF APPLICABLE
- **Massachusetts Immunization Requirements** FOR YOUR REFERENCE

*NOTE: A Current Physical Exam is an exam completed within 1 year, prior to the date of arrival at school.

**EXAMPLE:** If your child’s most recent physical exam was done in October, 2019 then this exam is acceptable to begin the 2020/2021 school year, however a copy of the October, 2020 physical exam must be forwarded to Health Services upon completion.

**NEW STUDENTS:** Send a copy of the Immunization Record (complete, with month & year).

**NEW STUDENTS:** A PPD/Mantoux Test (Tuberculosis Screening) done within one (1) year of their arrival at St. Mark’s School is required.
An indication by the physician of “Low Risk” is not acceptable.

If you have any questions over the summer, please email myself at adriapavletic@stmarksschool.org or lesliedowst@stmarksschool.org.

All forms need to be returned via email to lesliedowst@stmarksschool.org or faxed to 508-786-6010.

Have a healthy and restful summer,

Adria Pavletic, RN, MA, MN, NCSN
Director of Health Services
SPECIAL NOTICE

➤ All Health Record Forms are to be returned via email to lesliedowst@stmarksschool.org or faxed to 508-785-6010.

➤ Health Record Form (Page 1) – Alternate Contact
   - this section of the form must be completed with a local contact who would be able to pick up your student in case of illness or emergency

➤ Immunization Update
   - Starting in the 2020-21 school year, all students entering 5th Form (grade 11) will need meningococcal conjugate vaccine, MenACWY (brand names Menveo or Menactra) for school entry. 5th Form entry: 1 booster dose of MenACWY received on or after 16 years of age. (1 or more doses of MenACWY are acceptable as long as 1 dose was received on or after 16 years of age.)

➤ Flu Immunizations
   - If your student will be seeing their primary care physician during the summer we would encourage you to inquire about getting the seasonal flu immunization at that time.
HEALTH RECORD

Students with incomplete health records will not be allowed to participate in any activities, including sports. This form MUST be returned to Health Services, St. Mark’s School, Southborough, MA 01772 no later than JULY 1st.

STUDENTS’s Name __________________________________________________________ Date of Birth ________________

Last                                      First                                      Middle

Home Address _____________________________________________________________________________________

Number and Street                             City                                    State                                    Zip

Student Cell Phone: __________________________________________

FATHER’s Name ____________________________________ Res. Phone (_____) ____________________

Home Address __________________________________________________________ Cell Phone (_____) ____________________

E-Mail: ______________________________________________ Bus. Phone (_____) ____________________

MOTHER’s Name ____________________________________ Res. Phone (_____) ____________________

Home Address __________________________________________________________ Cell Phone (_____) ____________________

E-Mail: ______________________________________________ Bus. Phone (_____) ____________________

ALTERNATE responsible person (not a parent) to be contacted if parent or guardian is unavailable:
__________________________________________________________________________________________________________

Address __________________________________________________________ Phone (_____) ____________________

INSURANCE PREAUTHORIZATION/REFERRAL REQUIRED? □ YES □ NO

PLEASE ATTACH A COPY OF THE HEALTH INSURANCE CARD (FRONT AND BACK) TO THIS FORM. REQUIRED ANNUALLY.

Health Insurance Company/HMO ____________________________________________

Name of Subscriber ________________________________________ Subscriber’s Date of Birth: ______________________

Subscriber’s Employer ____________________________________ ID/Group Number __________________________

PARENT PERMISSION:

I hereby consent for St. Mark’s School Health Services, or designated health care providers, to carry out accepted procedures for diagnosis and treatment of medical conditions, athletic injuries, dental injuries, counseling services, and medication administration for my daughter or son, ______________________ (Student Name). Any required immunizations that are not complete may be administered at Health Services. Furthermore, I understand that the exchange of pertinent medical, psychological, and health insurance information may be necessary when providing care with an outside provider or through an off-campus facility. Faculty and other school personnel will be informed of any life threatening allergies, medical conditions, and psychological issues which may require treatment as deemed necessary by Health Services.

Please sign and date below, to complete this authorization.

Parent/Guardian Signature ____________________________ Date ________________
**Health Record**

Student Name: ___________________________ Date of Birth: __________________

Would you like your child to receive the Flu Immunization? □ Yes □ No

**The Flu Immunization will be entered into your child’s MIIS Immunization Record**

Parent Signature __________________ Date __________________

**Parents/Students Please Complete the Following:**

Primary Care Physician: __________________ Phone: __________________

**Please list current medications:**

Please comment on all “Yes” answers in the space provided below. Please include dates and duration of condition if applicable.

<table>
<thead>
<tr>
<th>Medical History</th>
<th>Yes</th>
<th>No</th>
<th>Please Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies – Please describe reactions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Issues (fainting, palpations, ↑blood pressure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Issues (asthma, bronchospasms)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal Issues (Osgood Schlatters, scoliosis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal/Digestive Issues (special diet, lactose intolerant)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary/Menstrual Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic/Endocrine Issues (diabetes, thyroid)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic Issues (epilepsy, seizures, migraine headaches)</td>
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<tr>
<td>Sensory Issues (vision, hearing, speech)</td>
<td></td>
<td></td>
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<tr>
<td>Skin Issues (acne, eczema)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Issues (braces, retainer, implants)</td>
<td></td>
<td></td>
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<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic Injuries (fracture, sprain, strain)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Head Injuries (concussion)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss/Compromise of Any Paired Organ (kidney, lung)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent Infections (strep throat, tonsillitis, pneumonia)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal History</th>
<th>Yes</th>
<th>No</th>
<th>Please Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has physical activity been restricted during the past five (5) years? (Give reasons and durations)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Received counseling or treatment for an emotional, anxiety, or other psychological concerns?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diagnosed with learning differences? (ADD, ADHD, LD)</td>
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</tr>
<tr>
<td>Consulted or been treated by a clinic, physician, healer, or other practitioner within the past five (5) years?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns about activities of daily living? (sleep, diet)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns about tobacco, alcohol, or other drug use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns about issues related to sexual health? (STD, STI, contraception)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HEALTH RECORD (continued)
**Physical Exam Status**

**Note:** This Health Record Form **must** be returned to St. Mark’s School Health Services no later than July 1st. If your child’s next Physical Exam is scheduled at a later date, please indicate the date of the next scheduled Physical Exam below.

**Date of Next Scheduled Physical Exam:** ______________________

---

**Medication Information:**

**Medication Protocols**

All prescription medications must be checked in through Health Services. A Medication Order Form, signed by the prescribing physician, must accompany all prescription medications. This is both a health and safety issue. Authorized prescribers are limited to licensed physicians, dentists, nurse practitioners and physicians assistants working under the direct supervision of an MD.

All controlled substances, psychotropic medications, antidepressants, and narcotics will be kept in and administered from Health Services only. In the cases of medical marijuana prescriptions, Health Services must be appropriately notified, and accompanied by a written prescriber’s order. As with other controlled prescription medications, they are to be kept and administered in Health Services.

Students will be allowed to keep the following prescription medications in their dorm rooms after consulting with Health Services: Epi-Pens, inhalers, asthma/allergy medications, birth control pills, and acne treatments. Students will also be allowed to keep the following over-the-counter medications in their room: analgesics such as Tylenol (acetaminophen) and Advil (ibuprofen), cold medicines, antacids, vitamins, and herbal supplements. Students may not keep Nyquil, cough syrups, or caffeine products (such as Vivarin, NoDoz, Alert, etc.) in their rooms.

We expect students to be compliant with taking prescribed medications as per their prescriber’s instructions. It is the responsibility of the student to come to Health Services for the administration of medication according to these instructions. **Any parent with concerns about their child’s ability to comply with medication usage, within the boundaries of this policy, should contact Health Services directly.** If a dose is missed, Health Services staff may send the student an email or text message reminder. In cases of repeated missed doses, Health Services will notify the student’s parent and the advisor.

**Medication Distribution During Vacations**

Parents must make arrangements to keep a supply of their child’s prescription medications at home for the vacation breaks. If a parent chooses, they may pick-up the entire supply of medications to take home over vacation. Parents are responsible for re-supplying Health Services with the needed medications following the break. Students are not allowed to carry regulated, prescription medications to and from School. Medications not checked-in with Health Services will be considered contraband and will result in disciplinary consequences (Level III).
## St. Mark’s School Physical Exam Form

**RETURNING STUDENT**

<table>
<thead>
<tr>
<th>Student’s Name: ____________________________</th>
<th>Date of Birth: ____________</th>
<th>Sex: M___ F___</th>
</tr>
</thead>
</table>

### INTERVAL HISTORY: ILLNESS OR INJURY

**ALLERGIES:**

**EPI-PEN:** YES _____ NO _____

**RECENT ILLNESS OR INJURY:**

<table>
<thead>
<tr>
<th>Current Medications</th>
</tr>
</thead>
</table>

### ADDITIONAL RECENT IMMUNIZATIONS –

Date Given: ________________

### PHYSICAL EXAM – DATE OF VISIT:

Date: ________________ Height: ______ Weight: ______ BP ______ Vision: R ______ L ______

Significant physical and laboratory findings:

EXAM WAS NORMAL UNLESS ABNORMALITIES ARE LISTED BELOW.

This student may participate in all activities and competitive sports unless noted above.

**Examining Physician (Print Name):** ____________________________ **Signature:** ____________________________

**Address:** ___________________________________________________________ **Date:** ________________

**Physician Telephone:** ____________________________ **Physician Fax #:** ____________________________

**Physician E-Mail:** ____________________________________________________________________________
ST. MARK’S SCHOOL
HEALTH INSURANCE VERIFICATION FORM 2020/2021 (DOMESTIC STUDENTS ONLY)

St. Mark’s School requires that every student be covered by a comprehensive illness/injury plan that provides coverage for medical care while a student attends the school and is accepted by local practitioners. This requirement is designed to ensure the health and well-being of our students, and to comply with Massachusetts Law. Many U.S. families are insured under managed care programs such as HMOs and PPOs. These “network” plans often create obstacles such as up-front deductibles and co-payments if care is rendered away from home. **It is important to review carefully any coverage restrictions that may exist for students while away at school.** It is imperative and incumbent on you to contact your insurance company to discuss coverage options and procedures if your child needs care while at St. Mark’s and what deductibles and co-payments may be required when your child is away from home.

While basic services can be provided by the St. Mark’s School Health Services, emergency services, laboratory and diagnostic tests, prescriptions, and specialty care are not provided on campus. Questions to ask your insurance provider:

1. Is Emergency Care covered in Massachusetts?  Yes □ No □
2. Is Specialty Care covered in Massachusetts?  Yes □ No □
3. Are Prescriptions covered?  Yes □ No □ Which Pharmacy(ies)? ______________
4. Are Diagnostic Tests covered when ordered by a provider outside of the Emergency Room?  Yes □ No □

If your answers to these questions suggest that your coverage is limited to your local geographic area or only provides emergency coverage out of state, we suggest that you visit the Massachusetts Health Connector at [https://mahealthconnector.org/help-center](https://mahealthconnector.org/help-center) to research local options. If you qualify for a subsidized insurance program in your home state, it is likely that your child will qualify for subsidized insurance in Massachusetts as well. Your child’s change in residence to Massachusetts in September is a qualifying event that will allow them to enroll outside of the open enrollment period.

Once you have verified that your health insurance will work away from home or after securing the appropriate insurance for your child, please complete and sign the bottom portion of this form. Please attach a copy (front and back) of the insurance card and prescription card (if different) to this document. Please return the completed form and copies of the insurance cards to Health Services.

I have attached a copy of my insurance card(s): □ __________ PLEASE INITIAL

__________________________
INSURANCE COMPANY NAME

__________________________
POLICY NUMBER

__________________________
PHONE NUMBER

__________________________
PRIMARY INSURANCE HOLDER NAME

__________________________
PRIMARY INSURED DATE OF BIRTH

In making this selection, I accept full responsibility for all medical costs incurred by my child.

__________________________
NAME OF STUDENT

__________________________
SIGNATURE OF PARENT OR GUARDIAN

__________________________
DATE
Dear Parents,

At Walgreens, patient care is our top priority. Should your child require medication while attending St. Mark’s School, you can count on us to provide an exceptional level of personalized service – including direct billing!

It’s easy for you to take advantage of our direct bill service. All you need to do is provide us with some basic information. We’ll then bill your insurance and/or credit card or flex spending account. While St. Mark’s School will distribute the medication as directed, there’s no need for your child to bother with cards or money.

If you have any questions, please call Walgreens Pharmacy at 508-460-5323. We look forward to working with you and your child.

Sincerely,

Walgreens Pharmacy at Southboro Medical Group
24 Newton St
Southboro MA 01772

If you wish to be billed for your child’s medication, please fill out the form below and return it to St. Mark’s School Health Services.

**STUDENT NAME** _______________________________________________________________

**STUDENT DATE OF BIRTH** _______________________________________________________

Check here if student has school insurance (NO NEED TO PROVIDE INSURANCE INFORMATION) ☐

**PRESCRIPTION INSURANCE PLACE NAME** ____________________________________________

**RX BIN** ___________________________  **RX PCN** ___________________________

**ID#** ___________________________  **RX GROUP** ___________________________

**PRIMARY CARD HOLDER** ___________________________  **CARD HOLDER DOB** ______

**BILL TO (ENTER ONE) Credit Card:**  

**Account Number** ___________________________  

Expiration Date _______ Billing Zip Code _______

**Flex Spending:**  

**Account Number** ___________________________  

Expiration Date _______ Billing Zip Code _______

**HOME PHONE NUMBER:** ___________________________  **TODAY’S DATE** ___________________________

**PARENT NAME (PLEASE PRINT):** ___________________________________________________

**PARENT SIGNATURE:** ___________________________________________________________
Introducing the Massachusetts Immunization Information System, MIIS

Fact Sheet for Parents and Patients

The MIIS is a new statewide system to keep track of immunization records for you and your family. These records list the vaccinations (shots) you and your children get to protect against measles, chickenpox, tetanus, and other diseases. The goal is to make sure that everyone in Massachusetts is up-to-date with their shots and that your records are available when you need them – such as when your child enters school, when you need emergency medical help, or when you change healthcare providers.

What is the MIIS?

- A computerized system that collects and stores basic immunization information for people who live in Massachusetts.
- A secure and confidential system, as required by Massachusetts law.
- A system that is available for people of all ages, not just children.

How will it help me?

The MIIS:

- Helps you and your family get the best care wherever you go for your healthcare.
- Makes sure that you and your children don’t miss any shots or get too many.
- Can print a record for you or your children when you need it - if you move, if your doctor retires, or when your child starts school or camp.

Why is this important?

As you know, the schedule of shots needed to keep healthy can be very complicated. The MIIS:

- Helps your healthcare provider keep track of which shots are due and when they should be given.
- Keeps all your immunization records together for you, your family, and your healthcare provider.
- Provides proof of vaccination for your children.
- Helps prevent outbreaks of disease like measles and the flu in your community.
- Keeps shot records safe during natural disasters such as flooding or hurricanes.

What information is kept in the MIIS?

- A list of shots that you or your children have received as well as any that you or your children get in the future.
- Information needed for safe and accurate immunization of each patient, such as:
  - Full name and birth date.
  - Gender (male or female).
  - Mother’s maiden name (for children).
  - Address and phone number.
  - Provider office where each shot is given.

How does this information get into the system?

- Information about children is added when a child is born or when a child gets his or her first shots.
- Your healthcare provider can add your records or your family’s records if they are not already in the MIIS.
Who has access to my records?
• The Department of Public Health (DPH) uses modern technology to make sure that all information entered into the MIIS is kept secure and confidential.
• The information in the MIIS is only available to:
  o Healthcare providers or others ensuring appropriate immunization, as authorized by DPH.
  o Schools.
  o Local boards of health.
  o DPH, including the WIC program, and other state agencies or programs, that provide education and outreach about vaccines to their clients.
  o Studies specially approved by the Commissioner of Public Health which meet strict legal safeguards.

What if I don’t want to participate?
• You have the right to not participate at any time.
• To not participate, you need to fill out the ‘Objection or Withdrawal of Objection to Data Sharing’ form which you can get from your healthcare provider.
• If you decide not to participate, you will not have access to the benefits of the MIIS, like shared records about immunizations with schools and emergency rooms, and a complete record of shots in a single place.
• If you choose not to share your information, only your current healthcare provider will be able to see the shots they have given to you or your children, but not your complete immunization history.

How can I get more information?
Please visit our website at www.mass.gov/dph/miis, contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850, or ask your healthcare provider for more information.
MEDICATION ORDER

To be completed by Licensed Prescriber: Physician, Nurse Practitioner, or others authorized by Massachusetts General Laws, Chapter 94C.

NAME OF STUDENT: ___________________________________________ DATE OF BIRTH: _____________

ADDRESS __________________________________________________ GRADE: ___________

NAME OF LICENSED PRESCRIBER: ________________________________________________

ADDRESS OF PRESCRIBER: _______________________________________________________

BUSINESS TELEPHONE: _________________________ FAX NUMBER _________________________

DIAGNOSIS: _________________________________________________________________

Any other medical conditions: _____________________________________________________

MEDICATION: ___________________________ Strength: ___________________________

Dosage: ___________________________ Frequency: _________________________________

Route of Administration: _______________________________________________________

Specific instruction/information for administration: _________________________________

Date of Order: ___________________________ Discontinuation Date: ___________________

OPTIONAL INFORMATION:

Side effects, contraindications, or possible adverse reactions to be observed for: __________

________________________________________________________________________________

Other medication being taken by the student: __________________________________________

Date of next scheduled visit/advised return by Prescriber: _____________________________

Consent for self-administration
(provided the School Nurse determines it safe and appropriate): Yes _____ No _____

SIGNATURE OF LICENSED PRESCRIBER: ___________________________________________

Date ______________________________