PREP MARIANAPOLIS

Required Health Forms
Summary of Contents of Health Forms pages 1-8

<u>All student health forms must be completed every year by new and returning students, and must be received as early as possible for review but no later than August 1st.</u>
The Parent/guardian portion of the health forms can be sent at any time throughout the summer (pages 1, 2 & 6). Your student's physical must be done after June 1st to be accepted for the school year. The Extracurricular Clearance Participation Form is available for those with conflicting Physical Exam date requirements. Your child will not be allowed to participate in any sports tryouts, practices, or games until a physical, completed Emergency Treatment form (page 1), and, if required, signed clearance participation form has been received.

Testing for COVID-19 is required only of boarding students prior to arrival to campus. Please see Marianapolis website for up to date information on required COVID-19 test and timing of testing. **<u>PCR Antibody Testing will not be accepted as this only demonstrates an individual has had an exposure to the virus but cannot detect if there is an active asymptomatic (no symptoms) or symptomatic (with symptoms) individual carrier.</u>** Proof of testing is required 14 days prior to the arrival to campus.

Diagnostic tests for current infection
If you want to know if you are currently infected with the COVID-19 virus, there are two types of tests: molecular tests and antigen testing.
Molecular tests (also called PCR tests, viral RNA tests, nucleic acid tests)
How is it done? Nasal swabs, throat swabs, and tests of saliva or other bodily fluids.
Antibody Testing not acceptable as it does not detect active infection only that a person may have been exposed to the virus previously.

It is highly recommended all students be vaccinated for seasonal influenza each new school year and especially with the recent pandemic of COVID-19 to provide a safer school community.

Day and Boarding Students will not be allowed on campus until all health forms, documentation, medications, and COVID-19 testing has been completed and submitted for review via email.

In addition, all international boarding students will be required to have a Quantiferon Gold Blood or T-Spot Test for Tuberculosis after June 1st of the new school year. A PPD Skin Test or chest x-ray will no longer be accepted. Students will not be allowed to return to campus until all conditions are met.

Page 1: School Emergency Treatment Form. (Contact information, allergies, medical conditions, medications, and insurance information is kept for every student in case of an emergency. Accurate insurance information is important so your child is not delayed in receiving care and you are not misbilled.)

All Boarding Students: Must have a legal guardian/emergency contact in which if determined ill with suspect of CoVid must be located in the United States, able to pick up your child within 24 hours, assumes the responsibility of the student including quarantine/isolation medical intervention and care.

Page 2: Personal Medical History Form. (Utilized in case of emergency. Completed by a parent/guardian.)

Page 3: Information about state mandated immunizations. (A summary of requirements for Connecticut. This information is translated for your convenience.)

Page 4: Immunization Form. (If your doctor has a separate record preprinted for immunizations, you may write, "see attached" and please include the record.) In addition, all international boarding students will be required to have documentation of **Quantiferon Gold Blood or T-Spot Blood Test documented here with proof of blood test attached.**

Page 5 & 5B: Physician's report of physical exam - must be done after June 1st. (If your doctor has a separate record preprinted for the physical, you may write "see attached" and please include the record.) <u>If your child's physical is scheduled for before June 1st or after August 1st, please have Physician complete Extracurricular Clearance form (Page 5B).</u>

Page 6: Medication Policy and consent for over the counter medications. (Allows for medications to be administered to your child for common illnesses and/or treatments.

Page 7: **Day/Boarding Students - Permission to give medication at school is required if your student needs to take any medication which is not a standing order at school. Medication orders are required if a day student participates in any overnight stay in the dorms or trip off campus and needs to take their medication.** If your child requires a daily medication, have your doctor complete it at the time of their physical. **If your child has an Epipen and/or inhaler, a medication order must be completed, signed, and dated by a parent/guardian. An Epipen and/or inhaler in required to be kept in the Health Office with the original prescription label.** The student should also keep an Epipen and/or inhaler in their sports bag at all times. This is required in order to be cleared for extracurricular activities.

Due to COVID-19 and decreasing unnecessary contact to staff, all medications will need to be mailed to the Health Office before the start of the school year.

Page 8: Boarding Students – Blank form to be signed by parent/guardian. Permission to give medication at school is required if your student needs to take any medication which is not an above standing order. All boarding students' parents/guardians must sign, whether they currently take medication or not, in case medication needs to be prescribed by a healthcare provider.

Health Forms can be emailed to the school health office: healthoffice@marianapolis.org
Faxed to 860-288-8614
Mailed to Marianapolis Preparatory School: Attention Health Services
P.O. Box 304
26 Chase Road
Thompson, CT 06277

MARIANAPOLIS PREPARATORY SCHOOL EMERGENCY TREATMENT FORM

This form is required for all students. Parent/guardian signature is also required.

ALL FORMS MUST BE RETURNED TO THE HEALTH OFFICE BY AUGUST 1ST

Student Last Name: ____________________ Student First Name: ____________________ Nickname: ____________________

Student Grade: ________________________ Student DOB: ________________________

Student Gender: Male ____ Female ____ Residential Status: Day ____ Boarding _____ Enrollment Status: New _____ Returning _____

Mother/Guardian Name: ____ Father/Guardian Name: ____

Parent/Guardian Address: ____

Alternate/Additional Addresses: ____

Mother/Guardian Cell Phone: ____________________________________ **Father/Guardian Cell Phone: ___________________________________**

Mother/Guardian Email: ____ **Father/Guardian Email: ______________________________________**

Mother/Guardian Business Phone: ____ Father/Guardian Business Phone: ____

Home Phone(s): ____ Additional Phone: ____

Doctor's Name: ____ Doctor's Phone: ____

Doctor's Address: ____ Doctor's Fax: ____

Dentist's Name: ____ Dentist's Phone: ____

Date of Last Tetanus Shot: _______________________ **Allergies** (to medications, food or environment) ____

Medical Conditions/Limitations: ____

Current Medications: ____

Name and relationship of person to reach in case of emergency other than parent/guardian:

Name: ____ Relationship: ________________ Phone: _________________________ Location (State): _____________

Authorization to Marianapolis Preparatory School for Emergency Medical or Surgical Treatment

Authorization is hereby given to Marianapolis Preparatory School to act in the place of the parents/guardians of:

Should any emergency medical or surgical treatment or hospitalization be required during the school year or years the student is enrolled in the school. It is understood that the school and hospital authorities will make a bona fide effort to contact parents/guardians and the family physician (pediatrician) before acting on this authorization. Authorization is also given to Marianapolis Preparatory School to release any medical or medical insurance information if medical or surgical treatment is needed.

Signed: (Parent or Guardian)____Date: ____________________________________

Authorization to Treating Physicians/Hospitals/Hospital Personnel for Emergency Medical or Surgical Treatment

Authorization is hereby given to the physician(s), dentist(s), hospital(s) or hospital personnel selected by Marianapolis Preparatory School to hospitalize or determine proper treatment for, and to order medication, anesthesia, or surgery for:

(Print name of student)____

Should any emergency medical or surgical treatment or hospitalization be required during the school year or years the student is enrolled in the school. It is understood the school and hospital authorities will make a bona fide effort to contact parents/guardians and the family physician (pediatrician) before acting on this authorization.

Signed: (Parent or Guardian)____ Date: ___________________________________

Health Insurance Policy Holder Name: _______________________ Company: _________________________Policy Number: ___________________________

Policy Holder Social Security Number: ____Policy Holder Date of Birth: ___________________

Policy Holder Employer and Address: ____Insurance Phone #__________________________

***Please make a copy of the front and back of your insurance card and send it with these forms.**

Insurance information must be completed by day and boarding students. International Boarding students do not need to complete the insurance information, as they will be enrolled in the school's insurance.

MARIANAPOLIS PREPARATORY SCHOOL PERSONAL MEDICAL HISTORY

To be completed by student's parents/guardian prior to completion of Physician's Report of Physical Examination.
(Questions 7-102, if answered "yes," are to be fully explained in the space provided)

HAS THE STUDENT EVER HAD OR HAS ANY OF THE FOLLOWING:

CHILDHOOD DISEASES	**YES**	**NO**	**SYMPTOMS CONTINUED**	**YES**	**NO**	**DISEASES OR DISORDERS CONT.**	**YES**	**NO**
1. COVID-19			36.High or low blood pressure			72.Heart murmur		
2. Chickenpox			37.Neuralgia			73.Heart palpitation		
3. German Measles			38.Neuritis			74.Hepatitis		
4. Measles			39.Sciatica			75.Liver trouble		
5. Mumps			40.Phlebitis			76.Jaundice		
6. Whooping Cough			41.Varicose veins			77.Kidney trouble		
HISTORY – OTHER			42.Speech difficulties, stutter or stammer			78.Frequent urination		
7. Appendectomy			43.Stomach or intestinal trouble			79.Poliomyelitis		
8. Back trouble			44.Weight gain or loss			80.PTSD		
9. Enuresis			**DISEASES OR DISORDERS**			81.Psychosomatic Symptoms		
10.Hernia or Rupture			45.Allergies			82.Rheumatic fever		
11.Malaria			46.Anemia, Albumin, or other blood disease			83.Rectal Disease		
12.Meningitis			47.Amnesia, loss of memory			84.Piles		
13.Mononucleosis			48.Arthritis			85.Tonsillectomy		
14.Motion Sickness			49.Rheumatism or joint trouble			86.Other throat problem		
15.Nasal problems			50.Anxiety			87.Thyroid trouble		
16.Sinusitis			51.Asthma			88.Goiter		
17.Nightmares			52.Autism Spectrum Disorder			89.Tuberculosis		
18.Insomnia			53.Aspergers			90.Other lung disease		
19.Sleepwalking			54.ADHD			91.Ulcer – Stomach or Duodenal		
20.Scarlet Fever			55.Bipolar			92.Urinary Tract trouble		
SYMPTOMS			56.Cancer			93.Genital trouble		
21.Blood, pus or sugar in urine			57.Tumor			94.Sexually Transmitted Disease		
22.Brace or back support			58.Cyst or growth of any kind			**FAMILY HISTORY – Have any of your relatives ever had any of the following?**		
23.Bone, joint, or other deformities			59.Colitis					
24.Chronic cough			60.Enteritis			95.Tuberculosis		
25.Recurrent colds			61.Coronary heart disease			96.Diabetes		
26.Chest pain and/or pressure			62.Angina			97.Kidney Disease		
27.Cramp in legs			63.Concussion or unconsciousness			98.Heart Disease		
28.Chronic diarrhea			64.Other head injury			99.Arthritis		
29.Difficulty with coordination or locomotion			65.Depression			100. Stomach Disease		
30.Dyslexia, or other reading problems			66.Diabetes			101. Asthma		
31.Eye Trouble			67.Eczema or other skin disease			102. Epilepsy, Convulsions		
32.Fainting episode			68.Epilepsy or other apastic conditions					
33.Convulsion			69.Headaches or migraines					
34.Foot trouble			70.Hearing difficulty					
35.Gum or mouth trouble			71.Otitis media					

Please use this space to explain any box marked "Yes" above:

IMMUNIZATION EXEMPTIONS are permitted under certain circumstances. According to state law a child can be exempted from receiving a vaccine for medical conditions, which are contraindicated, or for religious reasons. If one of these circumstances is true for your child please go to the link below for additional information on if it's acceptable and what documentation needs to be provided. Exemption forms are available in other languages at the State of Connecticut Department of Public Health. Immunizations Exemptions Certification Forms: http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388416

*Must be documented by a physician if medical exemption. An example would be allergy to the vaccine.
*Religious Exemption must be documented as to religious denomination and parent/guardian letter.

Immunizations are meant to protect the entire population and should not be taken lightly. The state law of Connecticut requires that all vaccines be completed prior to your student's arrival to school. Please submit documentation by August 1st if entering in September, or 3 weeks prior to anticipated start date if entering after September 15th.The school nurse will review all medical records and forms received and then approve admittance to Marianapolis if all requirements are met, or give further instruction as to what forms, immunizations or other necessary documents are needed. It is highly recommended per the CDC for everyone to be vaccinated for the seasonal influenza vaccine especially those in dormitory/communal living.

Immunization records and physician's physical must be translated into English. All international students must have a test done for Tuberculosis with millimeters of induration and treatment if needed in English.
If your international student has a health passport (yellow book), they must bring it with them and turn it in to the health office. If this is the only document for immunizations, please make a copy from the yellow book and fax or email it with the health forms. We want to make this a safe and healthy community to learn and grow; please help us to provide this goal by getting your health forms, documentation, immunization records and physicals in as soon as possible.

***** Translation Summary: Chinese, Korean and Spanish below:**

Chinese
翻译：中国微软
强烈建议每个疾病预防控制中心为每个人接种季节性流感疫苗，尤其是在宿舍/公共生活场所的人。免疫接种是为了保护整个人口。康涅狄格州法律规定，学校学生的到来之前完成所有的疫苗。不应被接收，如果进入九月文件的学年不迟于 8 月 1 日。如果您的学生进入后，9 月文档人人享有卫生保健的形式和身体应不迟于 3 个星期没有收到学生的到来之前。记录必须是英文。学校护士将审查所有的医疗记录和接受的形式，然后批准准入 Marianapolis 如果满足所有要求，或以什么形式，免疫接种或其他必要的文件，需要进一步说明。如果您的国际学生有一个健康护照（黄皮书），他们必须带他们，并把它在卫生厅。如果这是唯一的文件，请为预防接种，健康形式黄皮书传真或电子邮件的副本。形式可以在网上完成, 现在的学生生活，然后按一下当时的卫生保健中心形式。我们想这是一个安全和健康的社会，学习和成长。请帮助我们提供这一目标，您的健康表格，文档，免疫记录和医生尽快物理。康涅狄格访问 www.ct:gov/dph/cwp/view.asp?a=3136Q=467374&PM=1 入学的要求
表格上线，可以在 PDF 格式和文本输入到形式和电子邮件。

Korean
계절별 인플루엔자 백신, 특히 기숙사 / 공동 생활에있는 백신을 접종받는 사람은 모두 CDC 에 따라 적극 권장됩니다.
학생들의 종합검진 서류는 8 월 1 일 안에 제출하셔야 하고, 9 월에 입학하지 않는 학생들은 학교에 도착하기 적어도 3 주전에는 제출하셔야 합니다. 학교 간호사가 모든커네티컷 주 법에 의하면 모든 학생들은 새 학기가 시작하기 전에 미리 예방접종을 받아야 합니다. 9 월에 입학하는 모든학생들의 서류를 검토하고 혹시나 빠진 것이 있으면 알려드릴것이고, 종합검진이나 모든 서류는 영어로 번역이 되어야합니다. 더 안전하고 더 나은 커뮤니티를 위해 모두 협조하여 주시길 바랍니다. 감사합니다학교 입학 방문 한 코네티컷 요구양식은 라인에 있으며에서 PDF 형식과 텍스트 형태로 입력하고 이메일로받을 수 있습니다입력 양식을위한 코네티컷 요구 사항은 www.ct:gov/dph/cwp/view.asp?a=3136&Q=467374&PM=1 학교를 방문하여 온라인 및 PDF 형식이고, 당신이 방식과 텍스트를 입력할 수 있습니다 이메일.학생 탭을 클릭 학교 생활 Marianapolis 웹사이트로 이동하시기 바랍니다 후 보건 센터 및 건강 형태.

Microsoft Translator: Spanish
Según los CDC, se recomienda que todos se vacunen contra la vacuna contra la influenza estacional, especialmente aquellos que viven en residencias compartidas o comunitarias. Las vacunas están diseñadas para proteger a toda la población. La ley del estado de Connecticut requiere que todas las vacunas se completen antes de la llegada del niño a la escuela. ha documentcion debe ser recibida a mds tardar eLl de agosto, Si su hijo esta' entrando en septiembre despue's de la documentación, todas las formas de la salud física deben ser recibidas a ma's tardar tres semanas antesde la lleqada de los expedientes de suhijo. DEbe esbr en ingle's. ha enfermera de la escuela revisara' todos los expedientes me'dicos ylas formas recibidas y aprobadas despue's de la admision a MPS, si todos los requisitos son cumplidos, las instiucciones en cuauto a qoe' formas,vacunas u otios documentos necesarios son obligatonos. Para ver Requisitos que Connecticut para los formularcos de entrada de la escuela visita www.ct:gov/dph/cwp/view.asp?a=3136Q=467374&PM=1 estdr en linea yen formato pdf y se puede introducin texto en la form/par correo electrónico. Por favor viste la escuela MPS sitio web, haga unclic en la ficha estuddiantil, entonces centro de salud y las formas de la salud.

MARIANAPOLIS PREPARATORY SCHOOL
DEPARTMENT OF HEALTH IMMUNIZATION REQUIREMENTS

CONNECTICUT LAW REQUIRES FORM TO BE COMPLETED AND
RETURNED TO MARIANAPOLIS PREPARATORY SCHOOL PRIOR TO STUDENTS ARRIVAL.

Please submit documentation by August 1st if entering in September, or 3 weeks prior to anticipated start date if entering after September 15th.

<u>The following immunizations are mandatory for Grades 9-PG; documentation must be received prior to entering school.</u>

VACCINATION HISTORY Enter the month, day and year each immunization was given. Note that in the United States dates are written as follows**: month/day/year**

<u>DPT/DTaP/Td (Diptheria/Tetanus/Pertussis)</u> – at least <u>4 doses</u> with the last dose given at the age of 4 years
<u>Tdap booster</u> –dose given within the last 10 years
<u>Polio</u> – at least 3 doses with the last dose given after 4 years of age
<u>MMR (Measles/Mumps/Rubella)</u> –<u>2 doses</u> of MMR with the first dose given after the age of 1 year
<u>Hepatitis B</u> – <u>3 doses</u>
***Medical documentation of Varicella (Chicken Pox) disease <u>or two doses of the Varivax vaccine</u>**
<u>Menactra (Meningitis) - 1 dose</u> is required upon entering 7th-12th grade with a booster at 16 years of age.
<u>Seasonal Influenza (Flu Shot) - highly recommended due to COVID-19 and Communal Herd Immunity decreasing symptoms of the flu virus which is similar to COVID-19 Viral Symptoms.</u>

Vaccine		Doses			
Diphtheria-Tetanus-Pertussis		1*	2*	3*	
Tetanus Boosters		4	5		
Polio (OPV, IPV)		1*	2*	3*	4*
MMR		1*	2*		
Hepatitis B		1*	2*	3*	
Varicella (chicken pox)		1*	2*	Or History of disease. Date:	
Quantiferon Gold or SPOT Blood Test		Date:	Result:		
Menactra (Meningitis)					
Influenza (Flu Shot) Highly recommended annually		Date:			
COVID-19 Test		Date:		Result:	

I CERTIFY THAT THIS STUDENT HAS RECEIVED THE IMMUNIZATIONS INDICATED ABOVE:

Physician name: (print) ____

Physician signature:______________________________ Date: ____________

Laboratory confirmation of immunity is only acceptable for Hepatitis B, Measles, Mumps, Rubella, and Varicella.
A laboratory report must be provided.

VERIFICATION OF VARICELLA DISEASE: Confirmation in writing by a MD, PA, or APRN that the student has a previous history of disease, based on family or medical history.

Disease____________________ Date of Disease________

Certified by____

MARIANAPOLIS PREPARATORY SCHOOL

PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

Must be done after June 1st of enrollment year and be on file in health office by August 1st or additionally complete clearance participation form (pg 5B)

Name of Student: ______________________________

Age: __________ **Sex:** __________ **Height:** __________ **Weight:** __________

Blood Pressure: __________ **Pulse:** __________ **Posture:** __________

Nutrition: ______________**Note Marianapolis Preparatory School does not do vision, hearing or scoliosis screening.

Hearing (whispered voice, 15'): L: __________ **R:** __________ *Testing is not required, but recommended.

Vision: L: __________ **R:** __________ **Corrective lenses:** __________

Laboratory Tests: HGB: __________ and/or HCT: __________
*Blood work is not required for day students, but if the student had recent testing please include results. Blood work is recommended for all boarding students to have a baseline (CBC and metabolic panel H&H).

` Urinalysis: Glucose____, Protein_____

Physical Examination: Explain all positive findings in the space below.

Skin (including surgical scars):	Positive: ______	Negative: ______
Head/Neck (including eyes, ears, teeth, gums, nasal problems, thyroid):	Positive: ______	Negative: ______
Thorax:	Positive: ______	Negative: ______
Lungs:	Positive: ______	Negative: ______
Pelvic:	Positive: ______	Negative: ______
Urinary:	Positive: ______	Negative: ______
Skeletal:	Positive: ______	Negative: ______
Heart:	Positive: ______	Negative: ______
Abdomen:	Positive: ______	Negative: ______
Neurologic:	Positive: ______	Negative: ______
Extremities:	Positive: ______	Negative: ______
Allergies:	Positive: ______	Negative: ______

Scoliosis: No: ____ Yes: _____ (minimal) ______ (moderate) _____ (marked)__________

COVID-19 Virus exposure or diagnosis: No: _____ Yes: _____ (If yes, when) ______________

Student clear to return to school post-COVID-19 infection? No: __ Yes: _____ (If no, when expected?) _____________

Is this student in a higher-risk category for COVID-19? No: ____ Yes: _____

Please explain any positive findings: ______________________________

____

Is this student currently under physician's treatment for any medical or mental health condition? If so, elaborate:

____

____

____

Would this student be a candidate for mental health school counselor follow-up? No: ______ Yes: _______

I hereby certify that I have examined the above-named student and believe that he/she is physically able to engage in a full high school program, including athletics, physical education, and all other school activities without restriction.

Physician's name: ______________________________

Signature: ______________________________**Date of Actual Physical Exam:** ______________

If before June 1 or after August 1, please complete the Extracurricular Clearance (pg. 5B)

MARIANAPOLIS PREP

Clearance Form for Extracurricular Participation
To be completed by student's physician if their physical is before June 1 of the new school year or after the August 1 health forms deadline.

Date: ________________________

Student's Name: ____

Date of last physical exam: ____
(Please attach last physical and immunization record)

Is the above student cleared for sports, with no restrictions?

❒ Yes ❒ No

Date of next physical exam: ____
(Please provide updated copy to the Health Office on this date.)

Physician Signature: ____
Date Signed: __________________

Physician Recommendation:
____
____
____

Practice Name: ____

Phone Number: ____

** Note: This clearance form is considered to be a temporary clearance for extracurricular activities. Your child's physical should be scheduled as soon as possible for the new school year. A physical exam is required for every new school year. This form, or your child's physical, is required for them to participate in extracurricular activities.*

All Day & Boarding Students

MARIANAPOLIS PREPARATORY SCHOOL
MEDICATION ADMINISTRATION POLICY

The School has a clear and firm policy regarding the administration of **prescription medications and nonprescription medications.** When a student is required to take medications, parents/guardians should contact the school nurse to determine which category applies. No medications are to be brought to school without a physician order.

TYPE I: PRESCRIPTION MEDICATIONS (ORDINARY)

Prescription medications are generally administered at the Health Office. However, with permission from the school nurse, certain medications may be self-administered in the dormitory. Examples of these are antibiotic ointments and cleansers for acne, inhalers for asthma, and certain allergy medications. Prescriptions which are approved by the Health Office to be self-administered must be in their original containers, with a current Permission to Give Medication at School form filled out by the prescribing physician and on file in the Health Office**. Students may not be sent antibiotics or other prescription medications from home to keep in their rooms. All medications must be screened by the Health Office.**

TYPE II: FEDERALLY CONTROLLED SUBSTANCES

These medications must be stored and administered at the Health Office. Federally controlled substances such as, but not limited to, Adderall®, Dexedrine®, Ritalin®, Fiorinal®, Concerta, Prozac, Vyvanse and Tylenol® #3 (with Codeine) are not allowed in the dormitories, nor may they be self-administered. Medications such as antidepressants, anti-anxiety, behavior and sleeping pills are also included in this category.

TYPE III: OVER-THE-COUNTER MEDICATIONS

Over-the-counter (OTC) medications such as Advil®, Tylenol®, antacids, cough and cold medications should not be kept in the dormitories unless previously approved or provided by the Health Office. This is to prevent self-treatment by the student, which may lead to delayed care in more serious conditions (for example: bronchitis, pneumonia and strep**). Vitamins and supplements may be kept by students in the dorm only when the nurse is notified and a physician order is obtained. Permission from parents/guardians to give OTC's is needed before any medications can be given.** The School Physician has written Standing Orders for Advil®, Tylenol®, Robitussin®, Sudafed®, Midol®, Pepto-Bismol®, Benadryl, cough drops and various ointments. These may be given with written permission of parents/guardians.

I, ___________________________________, give my permission to the School Nurse and designated school officials to give over-the-counter medications as ordered by the school physician to

_____________________________________ *(please print name of student)*.

Exceptions are:____.

____ _____________________________

Parent/guardian signature **Date**

***Must be signed by all parents/guardians to give permission for over-the-counter medications to be administered.**

Students with Medication

MARIANAPOLIS PREPARATORY SCHOOL
PERMISSION TO GIVE MEDICATION AT SCHOOL

This form is required for boarding and day students who take regular medication. Parent/guardian signature is also required.

THIS FORM MUST BE RETURNED TO THE HEALTH OFFICE

Marianapolis Preparatory School requires that all students who need medication during school or anticipate going on an overnight field trip must do the following:

1. Present this form filled out and signed by the prescribing physician and/or dentist and the parent or legal guardian. **One form must be submitted for each medication prescribed.**
2. **PART I OF THE FORM *MUST* BE SIGNED BY A PARENT/GUARDIAN, OR THE MEDICATION WILL NOT BE ADMINISTERED. THE PARENT/GUARDIAN MAY CHOOSE TO SIGN PART II OF THE FORM.**
3. Bring the medication in the ***ORIGINAL PRESCRIPTION CONTAINER***, properly labeled by a registered pharmacist as prescribed by law.
4. **ALL CONTROLLED MEDICATIONS (*I.E.*, RITALIN®, TYLENOL® #3, ETC.)** must have a written prescription and blister count pack if available by pharmacy.

TO BE FILLED OUT AND SIGNED BY PRESCRIBING PHYSICIAN/DENTIST:

Student's full name: (Last, First)____________________ **Student's DOB:** ____________

Name of medication: ____________________________

Reason for medication: ____________________________

Size of tablet (mg.): ____________________ Amount of liquid (mg./tsp.): ____________

Specific time(s) and dose(s) to be given at school, and route: ____________________

Length of time: ____________ Every day: ____________ School days only: ____________

Are there any restrictions? *YES*: ______ *NO*: ______ If yes, what and how long? ____________

Medication can be self-administered with permission of school nurse *YES*: ______ *NO*: ______

Printed name of physician/dentist | Telephone number

Signature of physician/dentist | Date

TO BE COMPLETED BY PARENT/GUARDIAN

PART I: PERMISSION TO GIVE MEDICATION: **A separate form must be used for each medication. Copy this form as needed.*

My child is permitted to receive the above medication as directed.

*

Printed name of parent/guardian | Telephone number

*

Signature of parent/guardian | Date

PART II: PERMISSION FOR CHILD TO SELF-ADMINISTER TYPE I AND/OR TYPE III MEDICATIONS:

*

Printed name of parent/guardian | Telephone number

*

Signature of parent/guardian | Date

All boarding student parents please sign (*) consent for provider to prescribe medication as needed.

Boarding Students – Signed Blank Form

MARIANAPOLIS PREPARATORY SCHOOL
PERMISSION TO GIVE MEDICATION AT SCHOOL

This blank form is required for boarding students. Parent/guardian signature is required.

THIS FORM MUST BE RETURNED TO THE HEALTH OFFICE

Marianapolis Preparatory School requires that all boarding students provide an additional medication permission form in the event medication is required. All boarding students' parents/guardians must sign below in case a provider needs to prescribe medication:

1. Present this form filled out and signed by the prescribing physician and/or dentist and the parent or legal guardian.
2. **PART I OF THE FORM *MUST* BE SIGNED BY A PARENT/GUARDIAN, OR THE MEDICATION WILL NOT BE ADMINISTERED. THE PARENT/GUARDIAN MAY CHOOSE TO SIGN PART II OF THE FORM.**
3. Bring the medication in the ***ORIGINAL PRESCRIPTION CONTAINER***, properly labeled by a registered pharmacist as prescribed by law.
4. **ALL CONTROLLED MEDICATIONS (*I.E.*, RITALIN®, TYLENOL® #3, ETC.)** must have a written prescription and blister count pack if available by pharmacy.

TO BE FILLED OUT AND SIGNED BY PRESCRIBING PHYSICIAN/DENTIST:

Student's full name: (Last, First)__________________ **Student's DOB:** __________

Name of medication: __________________

Reason for medication: __________________

Size of tablet (mg.): __________________ Amount of liquid (mg./tsp.): __________

Specific time(s) and dose(s) to be given at school, and route: __________________

Length of time: __________ Every day: __________ School days only: __________

Are there any restrictions? *YES*: ______ *NO*: ______ If yes, what and how long? __________

Medication can be self-administered with permission of school nurse *YES*: __________ *NO*: ______

Printed name of physician/dentist __________ Telephone number __________

Signature of physician/dentist __________ Date __________

TO BE COMPLETED BY PARENT/GUARDIAN

PART I: PERMISSION TO GIVE MEDICATION: **A separate form must be used for each medication. Copy this form as needed.*

My child is permitted to receive the above medication as directed.

* __________ Printed name of parent/guardian __________ Telephone number

* __________ **Signature of parent/guardian** __________ Date

PART II: PERMISSION FOR CHILD TO SELF-ADMINISTER TYPE I AND/OR TYPE III MEDICATIONS:

* __________ Printed name of parent/guardian __________ Telephone number

* __________ **Signature of parent/guardian** __________ Date

All boarding student parents/guardians please sign (*) consent for provider to prescribe medication as needed.