WILBRAHAM & MONSON ACADEMY 2020-2021
423 Main Street Wilbraham, Massachusetts 01095 Phone 413.596.6811 Fax 413.596.3655 website: www.wma.us

MEDICAL AUTHORIZATION FORM

Check all that apply: ☐ New Student ☐ Returning Student ☐ Day Student ☐ Residential Student ☐ Male ☐ Female ☐ Non-Binary

Student's name: _____ Date of Birth(mm/dd/yy): _____

List of known allergies: _____

Chronic Illnesses: _____

Home Address: _____

City: State, Zip: Country:

Student lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Other: _____

Father's name: Email:

Address:

Father's Cell Phone: Home Phone:

Mother's name: Email:

Address:

Mother's Cell Phone: Home Phone:

Other Emergency Contact Person: Phone:

International Student
Guardian's name: Phone: _____

HEALTH INSURANCE IS REQUIRED (Health Insurance must have a U.S. address and phone number where claims can be submitted)

HEALTH INSURANCE CO: _____

Policy#_____ ID# _____ Group#_____

Ins. Co. Address_____

Ins. Co. Phone: _____

Subscriber's Name: _____ Date of Birth _____

Subscriber's Employer: _____

PERMISSION TO SUBMIT INSURANCE: I hereby authorize Wilbraham & Monson Academy Health Services and any hospital, physician or other person who has attended to or examined the above named student to furnish to the insurance company or its representative upon request any and all information (including medical records) with respect to any illness, medical history, consultation, prescription, treatment, or hospitalization. I understand that I am financially responsible for charges not covered by insurance.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

MEDICAL AUTHORIZATION: The undersigned hereby authorizes and grants Wilbraham & Monson Academy Health Services and/or a designated adult representative permission to administer care and treatment to the above named student. Treatment may include the routine care of injuries and illnesses; the administration of immunizations to meet the requirements of Massachusetts State Law; administration of over the counter and prescribed medication. If the student requires non-emergent treatment and care for illness/injury/health maintenance/rehabilitation/dental/mental health therapy, I grant permission for such care/treatment to be rendered. Additionally, if the student needs to be seen by a physician or medical facility in the event of an emergency, Health Services and/or a designated adult representative may make initial medical decisions on my behalf until a parent, guardian, or other emergency contact person can be reached. Health Services and/or a designated adult representative may authorize the physician in charge of my child's care to administer anesthesia and to perform such procedures/operations as may be deemed necessary in the diagnosis and treatment of him/her in case of an emergency ONLY if a parent, guardian or other emergency contact cannot be reached.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

A copy of this authorization shall be considered as effective and valid as the original.

2020-2021
Prescription Medication Order & Permission Form

Wilbraham & Monson Academy
423 Main Street
Wilbraham, MA 01095
Tel: 413.596.9130 Fax: 413.596.3655

This form is to be completed by **physician and **parent** before any prescription medication and be administered at Wilbraham & Monson Academy.*

STUDENT:_____DOB:_____Allergies:_____
==========

Name of Parent/Guardian:_____Relationship:_____

Please list medications taken at home:_____

I, the undersigned parent or guardian, give the permission to the school nurse (or academy personnel designated by the nurse) to administer the listed medication to my child or to supervise my child in taking the listed medication if approved to do so by the school nurse. I authorize the school nurse to share information about such medication administration, as the school nurse deems necessary for the health and safety of my child. I agree to release, indemnify and hold harmless Wilbraham & Monson Academy, and their employees from and against any claim either I or my child may have as a result of any act or omission that may arise out of this authorization.

Signature of Parent/Guardian:_____Date:_____
==========

Consent for self-administration

Has the student been instructed to self-administer medication and may the student do so at WMA?
YES__ NO__ (the school nurse must determine if it is safe and appropriate to do so)

PHYSICIAN: Please complete if this student must take prescribed medication at Wilbraham & Monson Academy

MEDICATION_____Order Date:_____

Dose_____Route_____Frequency_____

Diagnosis:_____Special Instructions:_____

Licensed Prescriber:_____
PRINT NAME

Signature of prescriber:_____Date:_____

Address:_____Phone:_____

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PHYSICAL EXAM FORM

Print this form and bring it to* your child's *physician to complete

Name _____ Date of Birth _____ (mm/dd/yy) Date of Exam _____ (mm/dd/yy)

To the examining Health Care Provider: Please correlate the student's medical history with your findings and record below. All entries must be completed.

Gender _____ Height_____ Weight _____ BP_____ Pulse _____

Vision: Right 20/ _____ Left 20/ _____

Vision with correction: Right 20/ _____ Left 20/ _____

	Normal	Abnormal	Details
Ears/Hearing, Nose, Throat			
Mouth, Teeth, Orthodontics			
Eyes – general			
Lungs, Chest, Breasts			
Heart/Vascular			
Gastrointestinal, Nutritional			
Endocrine (Diabetes)			
Genital – Urinary (hx. UTI)			
Spine, Scoliosis, Musculoskeletal			
Skin			
Neurological			
Psychiatric			
Menstrual Cycle history: Specify medication or problems			

Dental or eye care needed:_____

Is this student capable of normal physical activity? _____

If not, give reasons and limitations:_____

_____

ALLERGIES: _____

Is student taking any **medication?** _____

If so, for what purpose?_____

_____

Signature of examining Health Care Provider: _____

Address:_____

Date: _____ Telephone Number:_____

IMMUNIZATIONS 2020-2021

Student:_____ Date of Birth_____
First Name Middle Last Name mm/dd/yy

Required Vaccine	Dates Given	MA State Requirements
MMR	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____**MANDATORY**	2 doses **OR** positive titers Minimum of 4 weeks between doses 1st dose given after 1st birthday
Measles	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____	
Mumps	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____	Option of combined MMR **OR** individual vaccines
Rubella	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer date ____/____/____	
DTaP/DTP/Td	#1 ____/____/___ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____**MANDATORY**	5 doses mandatory for school entry. One dose for all students entering grade 7. Boosters every 10 years.
Tdap	#1 ____/____/____ **MANDATORY**	
Polio (IPV/OPV)	#1 ____/____/___ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____**MANDATORY**	4 doses mandatory for school entry. If 4 doses are given before age 4, then a 5th dose is required.
Menveo or Menactra	#1 ____/____/____ **OR** #2 ____/____/____	Grade 7: 1 does for all students Grade 11: 1 booster dose on or after age 16
Varicella	#1 ____/____/____ #2 ____/____/____ **OR** Positive Titer Date ____/____/____ **MANDATORY** **OR** History of disease: Date ____/____/____	2 doses varicella OR positive titer **OR** history of disease. Minimum of 4 weeks between doses if age 13 or older
Hepatitis B	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ **OR** Positive Titer HBs Ab Date: ____/____/____ MANDATORY	3 doses **OR** positive titer Minimum 4 weeks between doses 1 and 2 Minimum 3 months between doses 2 and 3
Hepatitis A	#1 ____/____/____ #2 ____/____/____	Hepatitis A is recommended
Guardasil/Cervarix	#1 ____/____/___ #2 ____/____/____ #3 ____/____/____	Recommended vaccine
Meningococcal B	#1 ____/____/____	Recommended vaccine

Tuberculosis Risk Assessment - Required for ALL students

To the best of your knowledge, have you had close contact with anyone who was sick with Tuberculosis .....Yes ☐ No ☐

Were you born in a country with high rates of TB (most Asian, African and South American countries) .....Yes ☐ No ☐

Have you traveled or lived more than a month in one of the countries with a high rate of TB? .....Yes ☐ No ☐

A history of BaccilleCalmette-Guerin (BCG) vaccination does not remove the requirement.

If a student has had a positive PPD in the past, and has not been treated for latent TB, a chest x-ray is required.

If a student has been treated for latent TB, no further testing is required but the treatment must be documented below.

Treatment for positive PPD? Yes ☐No ☐If yes, describe: _____

If you answered YES to any of the above questions, either PPD test (also known as Mantoux) OR Interferon Gamma Release Assay (IGRA) test must be completed within 4 months prior to entering the USA.

PPD (Mantoux) Test: *(Tine, Monova or Heaf tests are not acceptable replacement for Mantoux)*

Date read:_____(MM/DD/YY) **Results:** _____(actual mm or induration, transverse diameter)

IGRA: Positive☐ Negative☐ Indeterminate☐ Date: _____

Chest X-ray (If PPD is positive or IGRA is positive or indeterminate*)* **Results:** Normal ☐Abnormal ☐ Date:_____

Physician Name _____
Print *Signature* *Date*

Phone _____ Fax_____ email_____

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HEALTH HISTORY FORM

STUDENT _____ **Date of Birth** _____ **Sex:**___**M** ___**F**___**Non-Binary** **Entering Grade**___
First Name Middle Last Name mm/dd/yy

IMPORTANT NOTICE OF PRIVACY: This information is strictly for the use of WMA's Health Services Office in providing necessary health care while you are a student at Wilbraham & Monson Academy. Confidentiality of all health information will be strictly observed. It will not be released to anyone without your knowledge and consent. This page should be filled out by the student and/or parent and reviewed by the child's physician.

PERSONAL HISTORY: All questions must be answered. Comment on all "yes" answers on an additional sheet of paper.

Do you now or have you ever had the following:	Yes	No	Dates/Comments
Bronchitis/Pneumonia			
Chicken Pox			
Ear Infections			
Hepatitis			
Lyme Disease			
Malaria			
Measles			
Meningitis			
Mononucleosis			
Mumps			
Pertussis			
Shingles			
Sinusitis			
Tuberculosis			
HEADACHES			
Other			
Surgery			
Appendectomy			
Hernia Repair			
Tonsillectomy			
Other:			
Females Only			
Age of onset of menses			
Irregular Periods			
History of severe cramps			
GYN conditions			
Taking Birth Control Pill			
Other:			

FAMILY HISTORY	AGE	OCCUPATION
Father		
Mother		
Sister		
Sister		
Sister		
Brother		
Brother		
Brother		

VISION/HEARING/ SPEECH	Describe:		
Wears Glasses	Yes	No	
Hearing Aids			

ALLERGIES	Yes	No	Comments
Food			
Insects			
Other			
EpiPen Rx			
CHRONIC ILLNESS			
Cardiac			
Fainting/Dizziness			
Mitral Valve Prolapse			
Heart Murmur			
Other			
Endocrine			
Diabetes			
Insulin Injection			
Insulin Pump			
Thyroid			
Other			
Gastrointestinal			
Chronic Constipation			
Disordered Eating			
Ulcers			
Weight Changes			
Other			
Genito-Urinary			
Musculoskeletal			
Congenital Deformities			
Orthopedic Problems			
Surgery History			
Other			
Neurological Issues			
Concussion			
Seizures			
Learning Disabilities			
ADD/ADHD			
Other			
Psychiatric			Medication?
Anxiety/Panic			
Depression			
Sleep Disorders			
Substance Abuse			
Other			
Respiratory			
Asthma			Medication?
Other			

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STUDENT ACCIDENT & SICKNESS PLAN

Dear Parent/Guardian,

Out of concern for the health and welfare of our students, Wilbraham & Monson Academy requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by *local providers and practitioners*.

- Our health services will not accept medical insurance policies issued in a foreign country or from a company outside the United States.

To help you meet this financial responsibility, we offer a policy that will cover students during a 10-month period (Aug. 15, 2020 - June 14, 2021). This plan was designed especially for private secondary schools and meets the mandated requirements of Massachusetts law with benefits for those who do not have insurance or whose coverage is not accepted outside their geographical area. This plan will cover students anywhere in the world, *except their home country*, for a 10-month period for a premium of ($1,880) or a 12-month period (Aug. 15, 2020 – Aug. 14, 2021) for a premium of ($2,090).

INTERNATIONAL STUDENTS WHO DO NOT HAVE COVERAGE WITH A U.S.-BASED COMPANY (AS A DEPENDENT ON THEIR PARENT'S PLAN) MUST ENROLL.

If we do not hear from you, your child will be enrolled automatically, and the premium of $1,880 will be applied to the first tuition bill.

Please check the appropriate boxes below, include student's name, sign your name, date and return promptly to: rpower@wma.us or fax to 413.596.3655.

2020-2021 STUDENT INJURY & SICKNESS PLANS

1. [ ] Enroll (student) _____ in plan for:
[ ] A full 10 months (Aug. 15, 2020 - June 14, 2021 - $1,880)

2. [ ] Enroll (student) _____ in plan for:
[ ] A full 12 months (Aug. 15, 2020 - Aug. 14, 2021 - $2,090)

3. [ ] Do not enroll (student) _____ in the plan.
In making this selection, I accept full responsibility for all medical costs incurred by my child. My present in-force plan is as follows: (Please include a copy of the front and back of your insurance card)
****A COPY OF THE PRIVATE HEALTH INSURANCE CARD IS MANDATORY****

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

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

_____
SIGNATURE OF PARENT OR GUARDIAN **DATE**