MARVELWOOD SCHOOL

Health Forms Checklist 2021-2022

476 Skiff Mountain Road • Kent, CT 06757 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

The following forms MUST be received by the Health Office at least one month prior to the student's arrival on campus. If you are going to use Kent Station Pharmacy for medication refills, please go to: schoolforms.kentstationpharmacy.com and fill out the pharmacy forms.

- ☐ **1. Emergency Consent – REQUIRED**
  To be completed and signed by parent or guardian.
- ☐ **2. Personal History – REQUIRED**
  To be completed by parent or guardian.
- ☐ **3. Testing Consent – REQUIRED**
  To be completed and signed by parent/guardian and student.
- ☐ **4. Permission to Transport Medication**
  To be completed and signed by parent or guardian. Only required if student takes medication and parent/guardian wants student to be able to carry small quantities of medication to/from school.
- ☐ **5. Student Information for School Physician – REQUIRED**
  To be completed and signed by parent or guardian.
- ☐ **6. Health Insurance Information – REQUIRED**
  Please read and provide information as requested.
- ☐ **7. Influenza Vaccination Consent – HIGHLY RECOMMENDED**
  To be completed and signed by parent or guardian.
- ☐ **8. Physical Examination – REQUIRED**
  To be completed by Physician each school year. If physical exam is out of date or not provided your child will be sent to our school doctor to have one and the fee will be billed home.
- ☐ **9. Immunization History – REQUIRED**
  Needs to be filled out and completed by a physician initially for 1st year students and updated yearly only if vaccines are given by a physician at home.
- ☐ **10. Medication Authorization**
  Only required if student takes prescription medication.
- ☐ **11. Allergy Requiring EpiPen**
  Only required if student has a life-threatening allergy that requires an EpiPen.

If you have any questions please contact the staff at nurses@marvelwood.org.
Completed forms should be faxed, emailed, or mailed to:

Marvelwood School
Health Services
476 Skiff Mountain Road
Kent, CT 06757
Fax: (860) 927-2133
Email: nurses@marvelwood.org

MARVELWOOD SCHOOL

1. Emergency Consent 2021-2022

Must be completed and signed annually

476 Skiff Mountain Road • Kent, CT 06757 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

STUDENT'S NAME (Last, First, MI): _____ Grade _____

Student's Cell Phone:_____ Sex (M/F) Select... Date of Birth (Month/Day/Year)_____/_____/_____

Home Address: _____

_____

City: _____ State: _____ Zip Code:_____Country_____

AUTHORIZATION FOR CARE AND TREATMENT – Self-authorization by a student is not permitted.

I hereby authorize Marvelwood School to administer medical care and treatment, including medication and Connecticut mandated immunizations, and routine diagnostic tests for injuries and illness my child may incur while at school. I agree to notify Marvelwood School of any conditions arising when my child is not at school. I authorize the release of information and medical records to facilitate the medical, surgical or psychiatric care of my child. In the event of an emergency, illness or injury where there is an urgent need for treatment or which may affect the recovery of my child if not promptly treated and I am unable to be contacted, I authorize the school or its representative to assume the responsibility for the care and treatment of my child which may include hospitalization, diagnostic tests and/or surgery.

Parent or Guardian Signature:_____ Date:_____

Please print name:_____

PARENT/GUARDIAN INFORMATION

Student Resides with (Please circle one): Both Parents Father Mother Other Relationship _____

Parent/Guardian #1 _____Relationship_____ *Please circle preferred method of contact : home phone, work phone, cell phone, e-mail.*

Telephone: (H)_____(W)_____(Cell)_____

E-mail: (H)_____(W)_____

Parent/Guardian #2 _____Relationship_____ *Please circle preferred method of contact : home phone, work phone, cell phone, e-mail.*

Telephone: (H)_____(W)_____(Cell)_____

E-mail: (H)_____(W)_____

Alternate Emergency Contact _____Relationship_____ *Please circle preferred method of contact : home phone, work phone, cell phone, e-mail.*

Telephone: (H)_____(W)_____(Cell)_____

E-mail: (H)_____(W)_____

INSURANCE INFORMATION – Please attach a clear copy, front and back, of the student's insurance card.
Medical insurance is required for all students.
Marvelwood School is not responsible for payment of bills for health services.

EMERGENCY CARE INFORMATION:

Date of last TD Booster:_____ Significant Allergies (Drug/Food/Insect) or Health Issues_____

_____

MARVELWOOD SCHOOL

2. Personal History

Confidential – To be completed by parent and student

2021-2022

476 Skiff Mountain Road • Kent, CT 06757 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

TO THE STUDENT/PARENT: This information is strictly for the use of the Health Services Office in providing care. It will be treated confidentially. Please inform Health Services if there is any change of condition between completion of this form and the start of school. Please complete Personal History in full. Comment on all "YES" answers in the space provided or attach a separate sheet.

STUDENT'S NAME_____ Date of Birth (Month/Day/Year)_____/_____/_____

Do you have or have you ever had…?	YES	NO
ADHD/Learning Disability		
Alcohol or Other Drug Use		
Anemia/Blood Disorder		
Anxiety		
Asthma/Wheezing		
Back Problems		
Cancer/Tumor		
Cardiac Issues/Heart Disease/Heart Murmur		
Chest Pain/Shortness of Breath		
Counseling/Psychotherapy		
Dental Problems		
Depression		
Diabetes		
Headaches/Migraines		
Head Injury/Concussion		
Insomnia		
Meningitis		
Psycho-educational testing		
Psychological evaluation		
Recent Weight Change/Eating Concerns		
Seizures		
Tobacco Use		
Other Illness		

Women Menstruation: Age of Onset

Menstrual Problems

Birth Control Method

Personal History – Please complete in full.

Medication & Dosage *(regular or as needed)*	Therapeutic Program
	Hospitalizations (date & diagnosis)
Allergies to Medication	
Reaction	
Allergies to Food	Surgery (date & diagnosis)
Reaction	
Other Allergies	
What treatment is needed?	Significant Illness (date & diagnosis)

Please attach detailed information from physician

Family History – Biological (if available)

Relationship	Age	State of Health	Medical Issue(s)
Father			
Mother			
Brother(s)			
Sister(s)			

Are the student's parents separated/divorced? Yes____ No____

When?_____

Who has custody?_____

I declare that the information provided above is true and complete and that I have not withheld any information.

*Signed:*_____ *Date:*_____

MARVELWOOD SCHOOL

3. Testing Consent

Required annually for all students

2021-2022

476 Skiff Mountain Road • Kent, CT 06757 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

By signing this paper, my child and I agree that Marvelwood School can direct that my child be tested for the presence of drugs/alcohol in his/her system. We further agree that such tests can be random or regular, with or without cause. For any positive results, we also give permission for confirmation testing to be carried out by Quest Diagnostics to determine drug level.

You will be notified by the Dean of Students as soon as possible that the testing has taken place. In addition, you will be notified of the testing results in a timely fashion by the Dean of Students. Parents are responsible for laboratory fees associated with confirmation testing and any testing done on campus.

Parent name (print): _____

Parent signature: _____Date:_____

Student name (print): _____

Student signature: _____Date:_____

MARVELWOOD SCHOOL

4. Permission for Student to Transport Medications to/from School

2021-2022

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Permission to transport small quantity of medication for weekends/ college visits or a few days at home.

It is our policy that students are not to have any prescription, controlled, or over-the-counter medications, supplements or vitamins of any kind in their possession while on campus. The only exceptions to this policy are epipens, asthma inhalers and topical acne medications. Accordingly, students with permission to transport their own medication will either pick them up from the Health office or be given them to pack prior to departure on the day of travel, or the day before they travel. The day they return, please hand in any new medications or new medication orders to the nurse at the Health office.

In order to grant permission for your child to transport his/her medications to and from campus this school year, please sign and date the form below and e-mail or fax it to the Health Office. The signed form will remain in the Health Office files and is valid for the 2021-2022 school year.

This permission and privilege may be revoked by the school if the student does not comply with stated policies regarding transportation of medications. Students found mishandling or in possession of controlled or other medications while school is in session may be subject to disciplinary process.

I hereby request that my child _____ be permitted to transport his/her medications to and from campus during the 2021-2022 school year.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

Permission will not be accepted via telephone or email without the accompanying form.

Return original or legible faxed or emailed copy to:

Marvelwood School
Health Services
476 Skiff Mountain Road
Kent, CT 06757
Fax: (860) 927-2133
Email: nurses@marvelwood.org

MARVELWOOD SCHOOL

5. Student Information for School Physician

2021-2022

476 Skiff Mountain Road • Kent, CT 06757 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

The following information will be kept on file by our school physician, Dr. Roman Alder, in the event that your child needs medical care while at school.

STUDENT'S NAME_____ Sex M ☐ F ☐

Date of Birth (Month/Day/Year)_____/_____/_____ Social Security # (if available) _____

Parent/Guardian Name_____

Is it permitted for our staff to leave you a voicemail regarding medical information/lab results? Yes ☐ No ☐

If yes, what is the best telephone number at which to leave this information? _____

Race: ☐ American Indian ☐ Asian ☐ Caucasian ☐ Person of Color ☐ Other/Specify _____

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No

Native/Primary Language _____ Language Preferred _____

Please provide the following information as well as a clear copy of the front and back of your insurance card (domestic students only):

Insurance Name _____ Policy Name_____

ID# _____ Group # _____

Effective Date (Month/Day/Year)_____/_____/_____ Phone Number (Providors): _____

Policyholder's Name _____ Relationship to child_____

Policyholder's Date of Birth (Month/Day/Year)_____/_____/_____

Address (if different)_____ City_____State____ Zip_____

Does your insurance require a referral? Yes ☐ No ☐

If applicable, should we collect co-pay from ☐ student or ☐ parent/guardian? (circle one)

Who do we bill for deductables and/or co-insurance balances?

Name_____

Address_____ City_____State____ Zip_____

Pharmacy Name: Kent Station Pharmacy
Phone#: (860) 927-3725 Fax: (860) 927-3895
Address: 38 N. Main St. P.O. Box 672 Kent, CT 06757

I authorize the doctor to release any information including the diagnosis and records of any treatment or examination of my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me.

*Signature of Responsible Party:*_____ *Date:*_____

476 Skiff Mountain Road • Kent, CT 06757 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

Dear Parent/Guardian:

To protect our students and their families, Marvelwood School requires that every student be covered by a comprehensive insurance plan. The plan must cover illness and injury, and be accepted by our local providers and practitioners. It is your responsibility to contact your insurance company regarding the benefits available to your child while he/she is a student at Marvelwood School.

Domestic Students:
Please provide a clear copy of the front and back of your health insurance and prescription drug cards and complete all insurance information as indicated on the **Student Information for School Physician form.**

International Students:
All international students will be enrolled in Marvelwood School student health plan. The cost for coverage during the school year - 10 months is $2,395.00, or 12 months is $2,650.00.

MARVELWOOD SCHOOL

7. Influenza Vaccination Consent

2021-2022

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Due to the recommendation by the CDC (Center for Disease Control), the Health Office will be offering the seasonal influenza vaccine for all boarding students. Immunization helps to avoid a flu epidemic on campus during the school year. If you would like your child to receive this vaccination, please complete this form and return it to the Health Office. A fee will be charged to the student's account and will be billed home.*

*If not covered by insurance the fee will be charged to the students account.

STUDENT'S NAME_____ Sex M ____ F____

Date of Birth (Month/Day/Year)_____/_____/_____ Telephone Number _____

Address: _____

City_____ State_____ Zipcode_____

Yes ___ No___ Is the student allergic to gelatin, antibiotics, latex, eggs, thimerosal, or other vaccine component? If yes, circle which one.

Yes ___ No___ Has the student ever had a serious reaction to a flu vaccine in the past?

Yes ___ No___ Has the student ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?

Yes ___ No___ Does the student have long-term health problems with heart, lung, kidney, neuromuscular/neurologic, liver or metabolic (e.g. diabetes) diseases; or anemia or other blood disorders?

Yes ___ No___ Does the student have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past three months, has the student taken medication that weakens the immune system such as cortisone, prednisone, other steroids, or anticancer drugs; or has the student had radiation treatments?

Yes ___ No___ Is the student in close contact with a severely immunosuppressed person who requires protective isolation?

CONSENT FOR STUDENT'S VACCINATION

I hereby authorize the Marvelwood School Health Center Staff or other provider to administer the 2021 seasonal influenza vaccine to my child.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ *Date:* _____

MARVELWOOD SCHOOL

8. Physical Examination 2021-2022

To be completed annually by a Physician, APRN or PA

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STUDENT'S NAME_____Sex: M____ F____ Date of Birth (Month/Day/Year)_____/_____/_____

Height _____ Urinalysis: Sugar_____Albumin_____ S.G._____ Vision, Uncorrected: R_____L _____

Weight _____ Hematocrit/Hemoglobin_____ Vision, Corrected: R_____L _____

Blood Pressure_____ Orthodonture/appliances: _____ Glasses☐ Contacts☐ Correction☐

Pulse_____ _____ Hearing: Right_____ Left_____

Are the following systems normal?	Yes	No	Findings
HEENT, (Chronic Sinusitis?)	☐	☐	
Lymph nodes, Thyroid	☐	☐	
Skin	☐	☐	
Chest, Lungs	☐	☐	
Breasts	☐	☐	
Heart, High/Low Blood Pressure	☐	☐	
Abdomen	☐	☐	
GU, hernia	☐	☐	
Back, Extremities	☐	☐	
Scoliosis/pronation	☐	☐	
Neurologic	☐	☐	
Psychological	☐	☐	

Medications:_____

If yes, please complete Medication Administration Form

Signficant Allergies (Drug/Food/Insect):_____Asthma:_____

If requiring EpiPen, please complete Allergy Requiring EpiPen Form

* Is further evaluation or therapy recommended?_____

* Any significant medical problems not mentioned above?_____

Is the student approved for participation in: Team Sports? Yes____ No____ Adventure Sports? (climbing, canoeing, biking) Yes____No____

TB: In high risk group? Yes____ No____ *If yes, please report PPD/CXR results on Immunization History Form.*

Tuberculin test required for all international students, high risk domestic students, and students pursuing community service placements in child/elder care.

Physician, APRN or PA **Signature** (non-parent)_____

Print Name_____Address:_____

Town, City, Zip_____Date:_____

* *Physician: Please send a detailed summary of any chronic illness or medical problem including treatment and recommendations.*

Return original or legible faxed or emailed copy to:

Marvelwood School
Health Services
476 Skiff Mountain Road
Kent, CT 06757
Fax: (860) 927-2133
Email: nurses@marvelwood.org

*Note to parent: Please schedule all routine medical care (dental, dermatological, etc.) before school starts or during school vacation.

MARVELWOOD SCHOOL

9. Immunization History

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STUDENT'S NAME _____ Date of Birth (Month/Day/Year)_____/_____/_____

The following immunizations are required for school entry and must be completed before the student arrives at Marvelwood. Please indicate as month/day/year.

Tuberculin Test: Required for all international and high-risk domestic students within the year prior to entrance. If student's skin test is positive, you must send a report of the chest x-ray results.
Diphtheria/Pertussis/Tetanus: Three doses, provided 3rd dose given on or after 4th birthday, and Td/Tdap booster every ten years thereafter.
Polio: Three doses of all IPV or OPV, provided last dose given after 4th birthday.
Measles/Mumps/Rubella (MMR): Two doses required; 1st dose after 12 months of age.
Varicella (Chicken pox): Two doses or history of disease.
Hepatitis B (Hep B): Three doses. Dose one and two are separated by 28 days; dose three is separated from dose one by four months minimum, two months from dose two, on or after age 24 weeks.
Meningococcal: One dose at 11-12 years of age; booster at age 16.
COVID 19

The following immunizations are highly recommended:
Human Papillomavirus (HP V): Now highly recommended for males as well as females.
Hepatitis A (Hep A): 2 doses given six calendar months apart.

Tuberculin Test and Immunizations:

Tuberculin Test:
PPD Date:* _____ /_____ /_____ Result _____ mm induration
If positive skin test: Date of CXR _____ /_____ /_____ Please provide a copy of CXR report
TB Therapy initiated? Yes☐ No☐
BCG: Date _____ /_____ /_____ *PPD required regardless of prior BCG vaccination

☐ This domestic student is at low risk for TB

Diphtheria, Pertussis, Tetanus:
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____
Date of dose 3 _____ /_____ /_____
Date of dose 4 _____ /_____ /_____ Tdap
Date of dose 5 _____ /_____ /_____ Most recent booster _____ /_____ /_____

Polio:
Date of dose 1 _____ /_____ /_____ ☐OPV / ☐IPV (circle one)
Date of dose 2 _____ /_____ /_____ ☐OPV / ☐IPV (circle one)
Date of dose 3 _____ /_____ /_____ ☐OPV / ☐IPV (circle one)
Date of dose 4 _____ /_____ /_____ ☐OPV / ☐IPV (circle one)

Flu Shot:
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____
Date of dose 3 _____ /_____ /_____
Date of dose 4 _____ /_____ /_____

Measles, Mumps, Rubella (MMR):
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____

Hepatitis A:
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____

Varicella (chicken pox):
Hx of disease Date _____
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____

HPV:
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____
Date of dose 3 _____ /_____ /_____

Hepatitis B:
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____
Date of dose 3 _____ /_____ /_____

COVID-19 Vaccine:
Date of dose 1 _____ /_____ /_____
Date of dose 2 _____ /_____ /_____
Pfizer | Moderna | J&J (circle one)

Meningococcal Vaccine:
Date of dose 1 _____ /_____ /_____ ☐Menomune / ☐Menactra *(circle one)*
Date of dose 2 _____ /_____ /_____ ☐Menomune / ☐Menactra *(circle one)*

Stamp Required:

Other Immunizations: _____
_____

MARVELWOOD SCHOOL

10. Medication Authorization

Required if student takes prescription medication

2021-2022

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Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber and parent/guardian written authorization for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Parents/Guardians: please have the prescribing physician complete and sign this form, then sign and date where indicated. Completed forms should be returned to the Marvelwood School Health office. Use additional forms if necessary.

Name of Student: _____ Date of Birth (Month/Day/Year)_____/_____/_____

Allergies:_____

Medication Name	Dosage	Route	Frequency	Administration dates: to/from	Known Side Effects

Prescriber's Signature: _____ Date: _____

Prescriber's Name/Title: (TYPE, PRINT OR STAMP) _____

Prescriber's Address: _____

Prescriber's Telephone: _____ Fax: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby authorize that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

MARVELWOOD SCHOOL

11. Allergy Requiring EpiPen

2021-2022

Must be completed by Physician, APRN or PA only if student requires EpiPen

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Parent/Guardian *fills out this section:*

STUDENT NAME (Last, First, MI): _____

Primary Parent/Guardian Name:_____

Primary Parent/Guardian Contact Number:_____

Physician Name: _____

Physician Phone Number:_____

Physician, APRN or PA *completes the rest of the form:*

HISTORY OF ASTHMA:

Diagnosis:_____

Check all that apply to this student:

- ☐ High risk for severe reaction
- ☐ Food Allergy
- ☐ Stinging Insect

Specific Allergens:_____

_____

_____

Indicate the sequence to follow when student has ingested, or thinks he/she may have ingested above-named food, or is stung by an insect. **Number from 1 (most urgent) to 6:**

_____ Observe student for symptoms of anaphylaxis**

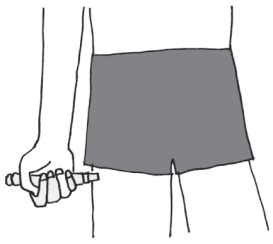
_____ Administer epinephrine BEFORE symptoms occur

_____ Administer epinephrine IF symptoms occur

_____ Administer Benadryl _____mg

_____ Transport to ER if symptoms occur

_____ Call 911 EMS and transfer to ER if EpiPen given



**Symptoms of anaphylaxis include:
Mouth: Itching, swelling of lips and/or tongue
Throat: Itching, tightness/closure, hoarseness
Skin: Itching, hives, redness, swelling
Gut: Vomiting, diarrhea, cramps
Lungs: Shortness of breath, cough, wheeze
Heart: Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly. Some symptoms are life-threatening! Act Fast!

Physician, APRN or PA **Signature** (non-parent)_____Date:_____