THE TAFT SCHOOL

110 Woodbury Road Watertown, CT 06795
TEL: 860-945-7762 FAX: 860-945-7766

Health and Medical History Records

SCHOOL FORMS TO BE COMPLETED AND RETURNED BY JULY 15th

Part I: *To be completed by parent / guardian*

Student's Name_____ Date of Birth _____ Male____ Female____ Other____
First Last

Student's Address: _____
Street/Apt # City State Zip code Country

Student resides with Father_____ Mother_____ If Divorced, Joint Custody? _____Other_____
(Please provide any specific instructions below about whom Taft may contact regarding this student)

_____

CONTACT INFORMATION:

List contacts in order of preference for being telephoned and check home (H) or work (W) or Cell

Parent / Guardian 1: _____ Tel: _____ H W Cell Relationship _____

Parent / Guardian 2: _____ Tel: _____ H W Cell Relationship _____

Additional Contacts:

Name: _____ Tel: _____ H W Cell Relationship _____

Name: _____ Tel: _____ H W Cell Relationship _____

Parent Email Address: _____

Student's Cell Phone Number _____

All students must name a 48-hour guardian who is available to collect the student within 48 hours of notification from Taft

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Highly Recommended: I give permission for my child to receive the Influenza Vaccine in the Fall

Yes _____ No _____

Parent / Guardian signature: _____ Date:_____

Parent/Guardian Signature: _____ Date: _____

This information is strictly for the use of the health center to provide necessary health care while your child is a student at The Taft School. In Loco Parentis: Due to the unique atmosphere of a boarding school, it may be necessary to discuss the health care of students, including Covid status, with pertinent School employees on a need-to-know basis to ensure the health and safety of the student and community when the School is acting in loco parentis.

Student Name _____

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MEDICAL HISTORY (Please indicate with dates)

Part II: *To be completed by parent / guardian*

1. Has student had any of the following? When?

Chicken Pox:	Musculoskeletal Disorder:
Tuberculosis:	Asthma:
Epilepsy / Convulsions:	Diabetes:
Difficulty Exercising:	Fainting:
Malaria:	Headache / Concussion:
Congenital Defect:	Speech / Hearing Difficulty:
Gain / Loss of Weight:	Kidney Disease:
Anxiety / Depression:	Mononucleosis:
Chemical Dependency (Drugs / Alcohol):	Tumor / Cancer / Cyst:
Learning Disability:	Eating Disorder:
Heart Disease:	Orthodontics:
Coronavirus:	Other:

Does your child wear glasses (Yes / No) or contact lenses (Yes / No)

(*Please attach a copy of prescription, as well as provide an extra set*)

2. Surgical Intervention: _____

3. Serious Injuries/ Hospitalizations: _____

4. Allergy to Food and/or Insect: _____

Please describe type of food/insect and reactions

5. Allergy to Medication: _____

Name of medication and reaction

6. Emotional Stress _____

7. Menstrual Problem/Issues: _____

8. Psychiatric and/or Drug/Alcohol Treatment: _____

9. Other Chronic Illnesses: _____

List all medications that the student will be taking while at school. Please have your physician complete a separate medication authorization form for each prescription.

Medication 1 _____Medication 2 _____

Medication 3_____Medication 4_____

Parent/Guardian's Signature: _____

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FAMILY MEDICAL HISTORY

	Age	State of Health	Occupation
Parent 1			
Parent 2			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			

Has anyone in the student's immediate family died before age 50? If so, of what? _____

I give permission for the release of appropriate medical information (including physician's physical) to Taft athletic trainers and coaches: *Please circle and initial* Yes _____ No _____

To the best of my knowledge, the above information given is complete and true:

*****Parent/Guardian Signature** _____Date: _____

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Part III: Infectious Disease Disclosure Release - *To be signed by parent / guardian*

Due to the ongoing public health emergency posed by the COVID-19 pandemic in a community setting, the School will notify the Taft community and public health officials when there is a confirmed COVID-19 case in the community. For Covid and other infectious diseases with community health implications, the School will disclose the student's name only with those people necessary to limit the spread of the disease on campus and for contact tracing, and will otherwise use its best efforts to avoid identifying information to ensure the privacy of the ill community member. By enrolling my child in Taft School, I authorize the disclosure of such infectious disease-related information as it pertains to the maintenance of community health on campus.

Parent / Guardian Signature _____ **Date** _____

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STUDENT PHYSICAL EXAMINATION PRIOR TO ENTRY

Performed by a licensed MD, PA-C, or NP

INCOMPLETE FORMS WILL BE RETURNED TO PARENT

Student's Name _____ Date of Physical_____

Date of Birth _____ Sex: Male ____ Female ____ Other _____ Allergies: _____

Height _____ Weight _____ BMI _____ Blood Pressure _____ Pulse _____

Vision: Right 20/_____Corrected to 20/ _____ Left 20/ _____ Corrected to 20/ _____

Corrected with Glasses _____ Contacts: _____

Examination of:	Normal	Abnormal	Comment on all "abnormal" answers
Head & Scalp			
Eyes (and fundi)			
Ears (and hearing)			
Nose			
Mouth & Teeth			
Pharynx			
Neck			
Thyroid			
Skin			
Lymph nodes			
Breasts			
Lungs			
Heart			
Abdomen			
Genitalia			
Extremities & Joints			
Spine			
Neurologic with Reflexes			
Emotional State			
Nutrition			

This student may participate fully in the Taft School Program

☐ Without Restrictions

☐ With the Following Restrictions (*Please explain)*

MD Signature: Printed Name: Date:

Urinalysis: SG _____ Sugar _____ Albumin_____ Cells _____

Hemoglobin/ Hematocrit _____

Has patient had BCG in the last 5 years? _____

*NOTE: BCG is not a replacement for a PPD. All students must have a PPD or QuantifFERON TB Gold Blood test within the year prior to arrival at Taft. There will be no exceptions to the requirement.

* Tuberculin test: Type_____ Given on ___/___/___ Reactions (in mm) _____ Read on ___/___/____

OR

QuantiFERON TB Gold Blood test on _____ Results: _____

If positive, CXR date: ___/___/___ Report (please include) _____ Treatment: _____

IMMUNIZATIONS AND LAB TESTING RECORD *Immunization record may be attached; Please sign the bottom of this page*

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (M/D/YY)

MEDICAL NOTES (allergies, vaccine reactions, etc.)

Vaccines			**Date Given** (m/d/yy)	**Date Given** (m/d/yy)	**Date Given** (m/d/yy)	**Date Given** (m/d/yy)	**Date Given** (m/d/yy)
Mandatory Immunizations	**Diphtheria, Tetanus, Pertussis** *5th dose after age 4 and before age 11*						
	Tdap booster (Td NOT acceptable) *1 dose required after age 11*						
	Polio (OPV/IPV)						
	MMR *2 doses required*						
	Varicella (chickenpox) *2 doses required*						
	Hepatitis B *3 doses required*						
	Meningococcal A (Menveo, Menactra) (MCV 4)						
	COVID (Two doses of CDC approved vaccine and booster required.) *For first-year international students only: Completed WHO series must be followed by complete two-dose series of CDC approved vaccine, the first of which must be completed prior to arrival on campus. Booster may be completed after arrival per CDC guidelines.*						
Recommended Immunizations	**HIB** (HPV 4, HPV 2)						
	Pneumococcal (PCV 7, PCV 13, PCV 23)						
	Hepatitis A *2 doses required*						
	Human papillomavirus (HPV 4, HPV 2)						
	Influenza (most recent only)						
Other	**Hemoglobin**	Date: Result:					
	TB testing	Date: Result:					

Recommendations: _____

MD/CLINCIAN SIGNATURE: _____ **Address:** _____

NAME (printed): _____