Summer Portals Student Health Form Instructions

• Please complete the health form and email the document to our office, summer@hotchkiss.org by June 1st.

• Page 1 and 2 should be completed by a parent / guardian.

• Page 3, 4, and 5 should be completed by a Health Care Provider. An immunization record document from the doctor’s office may be added in lieu of the Immunization Record page.

• Page 6 (Permission to Administer Medication) – if any medications are listed, a physician signature is required for this page.

• Please include a copy of the family insurance card (both sides) and a copy of the student’s Covid-19 vaccination card.

*International students are encouraged to purchase the school insurance for a fee. Domestic students may also purchase the school insurance if additional insurance coverage is needed. The school insurance is purchased through the Insurance Form in the student’s account. https://apply.hotchkiss.org/apply/status

The completed forms can be returned to our office via:
Email: summer@hotchkiss.org
Mail: Summer Portals, 11 Interlaken Road, Lakeville, CT 06039
Summer Portals Program(s): ____________________________________________

Student Name: ______________________________________________________
Resides with Parent One: Yes / No
Date of Birth: __________________________
Resides with Parent Two: Yes / No
Height: ________  Weight: ________  Age: ________  Other ______________________

Parent One Name: __________________________________________________
Email: ____________________________
Best Phone: home/cell __________________________
Second Phone: home/cell________________________

Parent Two Name: _________________________________________________
Email: ____________________________
Best Phone: home/cell __________________________
Second Phone: home/cell________________________

Emergency/illness Contact Name and Relationship: _______________________
Best Phone: home/cell __________________________
Second Phone: home/cell________________________
Email: ____________________________

If your child is a non-US resident, you must select the comprehensive insurance plan offered.

If you have US resident health insurance for your child, please list:

<table>
<thead>
<tr>
<th>INSURANCE COMPANY NAME</th>
<th>POLICY NUMBER &amp; PHONE NUMBER</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>INSURANCE COMPANY ADDRESS</th>
<th>CITY, STATE &amp; ZIP CODE</th>
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PLEASE ENCLOSE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD.

PERMISSION FOR MEDICAL CARE

I, the legal parent or guardian of __________________________, understand that in the event of a medical emergency no informed consent is required for my child’s treatment and that emergency medical care will be obtained and rendered to my child. I further understand that if my child’s medical condition is urgent but not life threatening, informed consent is required for treatment. If such a situation occurs and reasonable attempts to reach me for consultation and informed consent are unsuccessful, then I hereby delegate to the Medical Director of The Hotchkiss School or his/her designee or representative the authority to make on my behalf all medical decisions regarding the care and treatment of my child, including decisions on surgery and the administration of anesthetic, and to give informed consent to such treatment.

I also consent to, and authorize the Medical Director of The Hotchkiss School, his designee, and other School medical personnel to provide care and treatment (including administering medications and antibiotics) for my child’s routine health needs or conditions, such as colds, ordinary infections and minor injuries. I understand and agree that further specific consent will not be obtained at the time the routine care and treatment are provided and that the School will not notify me unless the Medical Director deems it appropriate or necessary.

Date ____________________________  Parent or Guardian Signature ____________________________
MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME: _______________________________ Date of Birth: ____________________________

Does your student have any allergies (include medications, insect stings, environmental, or food type)?  
☐ YES  ☐ NO  
If yes, please specify allergy and describe severity
__________________________________________________________

Does your student require an Epi-pen or Auvi-Q?  
☐ YES  ☐ NO

Does your student take any regular medications (include birth control, vitamins, supplements, etc.)?  
☐ YES  ☐ NO  
If yes, please specify medication and dose
__________________________________________________________

Has your student had any surgeries or hospitalizations?  
☐ YES  ☐ NO  
If yes, please list reason and the date
__________________________________________________________

Has your student ever been diagnosed with any of the following? Please provide details below.
☐ ADD/ADHD  ☐ Headaches/Migraines  ☐ Heart Problem or Murmur  ☐ Kidney Problems
☐ Alcohol or Drug Dependency  ☐ High Blood Pressure  ☐ Liver Problems  ☐ Lung Problems (other than asthma)
☐ Anemia or other Blood Disease  ☐ Rheumatologic Disease  ☐ Seizures  ☐ Sexually Transmitted Infection
☐ Anxiety  ☐ Skin Problems (eg. acne or eczema)  ☐ Thyroid or other Endocrine Problems  ☐ Tuberculosis
☐ Asthma  ☐ Gastrointestinal or Digestive Problems  ☐ Urinary Tract Infections  ☐ Other: __________________________
☐ Bipolar Disorder  ☐ Gynecologic Problems  ☐ NONE
☐ Blood Clots  ☐ Concussion or Head Injury  ☐ Depression  ☐ Diabetes
☐ Bone Problems or Fractures  ☐ Eating Disorder  ☐ Diabetes  ☐ Eating Disorder
☐ Cancer  ☐ Gastrointestinal or Digestive Problems  ☐ Thrombosis  ☐ Gynecologic Problems
☐ Concussion or Head Injury  ☐ Depression  ☐ Gastrointestinal or Digestive Problems  ☐ Thrombosis
☐ Depression  ☐ Gastrointestinal or Digestive Problems  ☐ Tuberculosis  ☐ Gynecologic Problems

Family History

Have any of your student's family members experienced sudden death at less than 55 years of age?  
☐ YES  ☐ NO  
If yes, please provide details
__________________________________________________________

Please provide any other relevant family history
__________________________________________________________

Completed by: ____________________________________________ Date: ________________________
STUDENT NAME: ____________________________ DATE OF BIRTH: _____________

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION BY HEALTH CARE PROVIDER REQUIRED:</th>
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<tbody>
<tr>
<td>Blood Pressure: _______ Pulse: _______ Height: _______ Weight: _______</td>
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<tr>
<td>Eyes: ___________________________ Heart: ______________________________</td>
</tr>
<tr>
<td>Ears: ___________________________ Murmurs: ___________________________</td>
</tr>
<tr>
<td>Nose and Throat: _______________ Enlargement: ___________________________</td>
</tr>
<tr>
<td>Teeth: ___________________________ Lungs: ______________________________</td>
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<tr>
<td>Skin: ___________________________ Abdomen: ______________________________</td>
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<tr>
<td>Lymph Nodes: ___________________ Extremities: ___________________________</td>
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</tbody>
</table>

**Allergies** to medications: __________________________________________________________

Other allergies: ____________________________________________________________

Epi-pen or Auvi-Q required □ YES □ NO Please specify: ________________________________

**Medications:**

□ NONE

List medications and dosages: ______________________________________________________

________________________________________________________________________________

*The Permission to Administer Medications form must be completed for all prescription medications. For compliance with safety standards, all medication that is required to be stored in the Health Center, including, but not limited to controlled narcotics, stimulant medications, and psychotropic medications, must be in pre-packaged individual dose packets as Health Center staff are not permitted to repackage medication. We have partnered with Petricone's Pharmacy for the delivery of medication to campus in the required packaging. We encourage you to establish an account with them by calling 860-489-5511.*

**Please provide details** of (1) psychiatric care or treatment, (2) fractures, (3) surgeries, (4) concussions, (5) any other problems beyond routine childhood illnesses.

________________________________________________________________________________

________________________________________________________________________________

Is this student capable of physical activity and participation in a competitive athletic program? □ YES □ NO

Please advise if there are any restrictions, conditions, or injuries. ________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Name of Examiner: ____________________________________________________________

Signature of Examiner: ______________________________________ Date: _____________

Address: __________________________ Telephone: __________________________

e-mail: __________________________ Fax: __________________________
**Immunization Record**

**Name of Student:** __________________________  **Date of Birth:** ________________

The following immunizations are **REQUIRED FOR STUDENTS TO ATTEND CLASSES by The State of Connecticut and/or The Hotchkiss School**. This form must be completed by a Physician, PA or APRN.

**DATE EACH DOSE IS GIVEN (month/day/year)**

<table>
<thead>
<tr>
<th>REQUIRED VACCINES</th>
<th>1st Mo/Day/Yr</th>
<th>2nd Mo/Day/Yr</th>
<th>3rd Mo/Day/Yr</th>
<th>4th Mo/Day/Yr</th>
<th>5th Mo/Day/Yr</th>
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<tbody>
<tr>
<td><strong>Polio</strong> – At least 3 doses required. The last dose must be on or after the 4th birthday.</td>
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<tr>
<td><strong>DTaP</strong> - At least 3 doses required, one of which should be Tdap.</td>
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<tr>
<td><strong>Tdap</strong> – Required</td>
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<tr>
<td>*<strong>MMR</strong> – 2 doses required. 1st dose must be on or after the 1st birthday and the 2nd dose must be at least 28 days after the 1st dose. <strong>If a student has a history of measles, mumps, or rubella it must be confirmed in writing by specific blood testing.</strong></td>
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<tr>
<td><strong>Varicella</strong> – 2 doses required or verification of disease. 1st dose must be on or after the 1st birthday. Minimum interval between doses: 3 months if person was younger than age 13 years, 4 weeks if person was age 13 years or older.</td>
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<td>Verification of Chicken Pox Disease by MD, PA, APRN, or lab confirmation:</td>
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<td><strong>Meningococcal</strong> – 1st dose required at age 11-12 years and a 2nd dose at age 16 years. If the 1st dose is given at 13-15 years, the 2nd dose should be at 16-18 years with at least 8 weeks between doses. If the 1st dose is given after the 16th birthday, a second dose is not required.</td>
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<td><strong>Hepatitis B</strong> – 3 doses required. At least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; 16 weeks between doses 1 and 3. Dose 3 should not be given before 24 weeks of age.</td>
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<td><strong>Hepatitis A</strong> – 2 doses required for those born on or after January 1, 2007. 1st dose must be on or after the 1st birthday and the second dose must be at least 6 months after the 1st.</td>
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<td><strong>COVID-19</strong> – please note specific vaccine received: ___________________________________________</td>
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<td>Booster Recommended</td>
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</table>

*If MMR and Varicella are not administered on the same day, they must be separated by at least 28 days.

**Additional Vaccines**

- Hemophilus (Hib)
- HPV (highly recommended)
- Meningitis B (recommended)
- Typhoid
- Yellow Fever
- OTHER

**Signature of Health Care Provider:** __________________________  **Date:** ________________
The Hotchkiss School
Mandatory Tuberculosis (TB) Risk Assessment Form

PHYSICIAN/PA/APRN Signature Required

Section A

1. Was the student born in a country with an elevated TB rate?
   Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
   □ Yes □ No

2. Has the student traveled to or resided for at least 1 month in a country with an elevated TB rate?
   Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
   □ Yes □ No

3. Is the student immunosuppressed, currently or planned?
   HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication.
   □ Yes □ No

4. Has the student had close contact with anyone with known active TB disease?
   □ Yes □ No

If the answer is “No” to all of the above questions, skip Section B and sign at the bottom of this page.
If the answer is “Yes” to ANY of the above questions, Section B must be completed and sign at the bottom of this page.

TB Testing Indicated

Section B:
Any student identified to be in a high-risk group must be tested for TB with either a skin test (PPD) or IGRA (Quantiferon Gold Assay). Testing must be completed within one year prior to admittance.

Has the student received the BCG vaccine?
□ Yes □ No

History of BCG vaccination does not eliminate the need for testing a member of a high-risk group. An IGRA (Quantiferon Gold Assay) is the preferred method of testing if the student received BCG. If you choose to complete a PPD as the initial test for a student who has received BCG vaccination, a positive PPD result with a negative chest x-ray will require further testing with the IGRA to determine if the PPD result is from the vaccine or latent TB infection.

PPD
Date Placed: Date Read: Result in mm = ________mm

IGRA – Quantiferon Gold Assay
Date: Result: □ Negative □ Positive □ Indeterminate

If either the PPD or IGRA (Quantiferon Gold Assay) is positive, a chest x-ray is required.

Chest x-ray Date: Result:

Please note, a chest x-ray alone is not sufficient screening as a PPD or IGRA (Quantiferon Gold Assay) is required to screen for latent tuberculosis.

Has the student been previously treated for latent or active TB infection?
□ Yes □ No If yes, please provide details:

Student Name: _____________________________ Date of Birth: ____________

Parent Name/Signature: _____________________________ Date: ____________

Physician/PA/APRN Name/Signature: _____________________________ Date: ____________
# Permission to Administer Medications

**Student Name:** ___________________________________________ **Date of Birth:** __________________________

**Allergies:** _____________________________________________

<table>
<thead>
<tr>
<th>MEDICATION and STRENGTH</th>
<th>DOSAGE (e.g. 2 tabs)</th>
<th>ROUTE</th>
<th>FREQUENCY</th>
<th>ADDITIONAL INSTRUCTIONS</th>
<th>REASON FOR TAKING</th>
<th>START DATE</th>
<th>STOP DATE</th>
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**PRESCRIBER NAME:** ___________________________________________ **PHONE:** __________________________ **FAX:** __________________________

**PRESCRIBER SIGNATURE:** ___________________________________________ **DATE:** __________________________

**Parent Name:** ___________________________________________ **Parent Signature:** ___________________________________________ **DATE:** __________________________