



The student health forms need to be filled out to completion each year the student attends Suffield Academy. A physical exam completed after March 1 is required for the upcoming school year\*\*. All requirements are due by August 1 for the academic school year. No student will be allowed to attend school or participate in any athletics or school activities until all Health Center requirements are fulfilled, uploaded to the Magnus Health Portal, and approved by the Health Center staff.

### Parent/ Guardian Student Health Forms Checklist [What to Upload & Where]

- Upload completed Physical Exam to the Student Health Form Section in Magnus.
- Upload Immunizations to the Immunizations section of Magnus. [Immunizations can be uploaded throughout the year].
- If your student requires emergency medications for allergies, asthma, diabetes, or seizures, please print the emergency action plans found in the Magnus Health Portal and have the forms completed by the student’s healthcare provider. Upload completed form[s] to the appropriate section[s] of Magnus.
- If your student takes any medication, please have the prescriber fill out the Medication Authorization form. Any medication prescribed for a student must be reported to the Health Center. Upload a form for each medication in the Prescription Medication Form section in Magnus.
- Complete all other Magnus Health Portal requirements. Some requirements are print and sign and others require an electronic signature.

\*\* For the academic school year: If your student CANNOT complete a physical exam between March 1 and August 1, please have the student’s healthcare provider complete the Provider Statement below.

<b>PROVIDER STATEMENT</b>	<b>To be completed by a licensed healthcare professional if your student cannot complete a physical exam between March 1 and August 1</b>	
<p>STUDENT NAME _____ DOB [MM/DD/YYYY] _____</p> <p><input type="radio"/> The healthcare provider has completed the TB Screening Questionnaire or TB Testing if needed.</p> <p><input type="radio"/> This student may participate fully in athletic activities and competitive sports based on their last physical exam dated _____.</p> <p><input type="radio"/> The next physical exam is scheduled for [MM/DD/YYYY] _____.</p> <p><input type="radio"/> The parent or guardian will upload to Magnus the following:</p> <p style="padding-left: 20px;">In the Student Health Form Section [You can only upload to this section once for the school year.]</p> <ul style="list-style-type: none"> <li>• Provider Statement</li> <li>• Student’s most recent Physical Exam</li> <li>• TB Screening Questionnaire and TB Testing form</li> </ul> <p style="padding-left: 20px;">Immunization Section</p> <ul style="list-style-type: none"> <li>• Immunization Records [You may upload to this section throughout the year.]</li> </ul> <p>Healthcare Provider Name [Printed] _____</p> <p>Healthcare Provider Signature _____</p> <p>Healthcare Provider Phone _____</p> <p>Healthcare Provider Address _____</p> <p>Date _____</p>		<p><b>PROVIDER STAMP</b></p> <div style="border: 1px solid black; width: 100%; height: 100%; margin-top: 10px;"></div>



SUFFIELD  
ACADEMY

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[SUFFIELDACADEMY.ORG/HEALTHCENTER](https://suffieldacademy.org/healthcenter)

Dear Parents,

Suffield Academy uses the Magnus Health Student Medical Record [SMR] to collect student health information for all students. Magnus Health SMR is a secure and easy-to-use website for submitting health information. Parents of new students will receive an email in June providing a username and password to access your child's Magnus Health SMR account. Parents of returning students will continue to use their current login information.

We request that all forms be faxed to Magnus or electronically uploaded to their website or mobile app. As a last resort, forms can be mailed or faxed to Suffield Academy's Health Center. We kindly request that you use the uploading process as much as possible.

Forms that must be downloaded, completed, and signed by your child's physician[s] are available at [suffieldacademy.org/healthcenter](https://suffieldacademy.org/healthcenter). Once you have your login information you can also access these forms via the Magnus Health website. Additionally, you have the option to download the Magnus Health app with your established account—we highly recommend utilizing the mobile app to complete your child's health forms.

Please note the following forms are required annually:

- Physical Exam [within one year]
- Required Immunizations [Suffield Academy follows Connecticut state requirements for immunizations]
- Tuberculosis Risk Assessment [required for domestic students only]
- Tuberculosis Medical Evaluation [required for international students only]

You may receive email reminders from Magnus Health during the summer regarding forms that are not yet submitted. Once you submit the information requested the reminders will stop. You may contact customer support at Magnus Health SMR by email or phone at 877-461-6831.

You can always update your child's medical history and are encouraged to do so whenever applicable. Magnus is a helpful tool that increases security while collecting and maintaining health information, as well as providing secure access to your child's information in the event of an emergency. By providing us with the required information you help us provide timely, appropriate, and safe care to your child.

Please contact me at the Health Center if you have any questions about the health forms or the above process:  
[rsmetana@suffieldacademy.org](mailto:rsmetana@suffieldacademy.org) | 860-386-4503

Sincerely,

Rachel Smetana '99, MS, RN  
Suffield Academy Director of Health Services



STUDENT NAME [FIRST & LAST]

DOB

## PHYSICAL EXAMINATION RECORD

ALL STUDENTS MUST HAVE A PHYSICAL EXAM THAT IS CURRENT [WITHIN 12 MONTHS] AT ALL TIMES TO PARTICIPATE IN SCHOOL PROGRAMS & ACTIVITIES.

EXAM DATE: \_\_\_\_\_ ALLERGIES \_\_\_\_\_

Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Height [inches] \_\_\_\_\_ Weight [pound] \_\_\_\_\_

Urinalysis \_\_\_\_\_

sugar \_\_\_\_\_

albumin \_\_\_\_\_

micro \_\_\_\_\_

Hemoglobin or hematocrit \_\_\_\_\_

Prior medical/psychological conditions \_\_\_\_\_

Previous musculoskeletal injuries \_\_\_\_\_

Current medical/psychological conditions \_\_\_\_\_

Psychotherapy or counseling history \_\_\_\_\_

**Asthma [If yes, please provide a copy of Asthma Action Plan]**

No  Yes  Intermittent  Mild Persistent  Moderate Persistent  
 Severe Persistent  Exercise Induced

**Anaphalaxis [If yes to food, please provide a copy of Food Allergy Action Plan]**

No  Yes  Food  Insects  Latex  Unknown Source

**History of Anaphalaxis**  No  Yes **Epipen Required**  No  Yes

## REVIEW OF SYSTEMS DESCRIBE FULLY [ USE ADDITIONAL SHEET IF NEEDED]

	WNL	ABNL
Head, ears, nose, throat		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
Any other conditions		

Please list dose and schedule for each medication

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For returning students only: please list immunizations since last physical.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My examination finds the student named above to be in good health, free from contagion, and physically and emotionally qualified for a full program of study and sports.

Yes  No If no, please explain \_\_\_\_\_

Print or type name and address of examining physician \_\_\_\_\_

PHYSICIAN'S SIGNATURE [REQUIRED]

\_\_\_\_\_ DATE



STUDENT NAME [FIRST & LAST]

DOB

## IMMUNIZATION HISTORY [NEW STUDENTS]

### Connecticut State Law requires the following [Suffield Academy follows these requirements]:

**Tdap/Td** One dose for students who have completed their primary DTaP series. Students who start the series at age seven or older only need a total of three doses of tetanus-diphtheria containing vaccine, one of which must be Tdap.

**Polio** At least three doses; the last dose must be given on or after fourth birthday.

**MMR** Two doses separated by at least 28 days; first dose on or after first birthday.

**Hepatitis A** Three doses given six calendar months apart; first dose close to or after 1st birthday if born after 1/1/07.

**Hepatitis B** Three doses; the last dose on or after 24 weeks of age.

**Varicella [chickenpox]** Two doses separated by at least three months; first dose on or after first birthday; or verification of disease.

**Meningococcal Conjugate** One dose.

**Immunization History: please list all dates; boxes with an \* are required and must include a month/day/year date**

	1	2	3	4	5	6
DTaP/Td	*	*	*			
Tdap	*					
TOPV/IPV [three doses; one dose after age 4]	*	*	*			
M.M.R	*	*				
Hepatitis B	*	*	*			
HIB						
Varicella [chickenpox]	*	*	Date of Disease:			
Meningitis Conjugate	*					
Meningitis B						
Hepatitis A	*	*	*			
Gardasil [HPV]						
Influenza						
COVID-19						

PHYSICIAN'S SIGNATURE [REQUIRED]

DATE



STUDENT NAME [FIRST & LAST]

DOB

**AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL**

Suffield Academy's preferred pharmacy: Partners Pharmacy, 61 Thompson Road, East Windsor, Connecticut 06088  
Phone: 860-623-3000 Fax: 855-547-5702 NPI # 1336170349 eScribe capable.

All medications must be packed in individual dosing packs. Partner's Pharmacy automatically packages medications in individual dosing packaging and will deliver them to school. They accept most insurances.

Any medication prescribed for a student must be reported to the Health Center. This form must be completed for all controlled substances, mood-altering medications, and any other medication to be dispensed by school personnel. Connecticut State statute requires a physician's or dentist's written order and the parent's/guardian's authorization for a nurse to administer prescription medicine.

Medications must be in pharmacy-prepared individual dosing packs and labeled with the student's name, name of the drug, strength, dose, frequency, physician's or dentist's name, and date of the original prescription. The physician's name and order must be the same on the authorization form and prescription bottle. All prescriptions may be included on this form. Photocopies of this form are acceptable.

**PHYSICIAN'S ORDER**

Diagnosis \_\_\_\_\_

I have evaluated/examined the student on \_\_\_\_\_ and plan to reassess the medication treatment plan on \_\_\_\_\_  
DATE DATE

Drug: [name, dose, frequency and method of administration] \_\_\_\_\_

Medication shall be administered from \_\_\_\_\_ to \_\_\_\_\_  
DATE DATE

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, give plan for management

Is this a controlled drug?  Yes  No If yes, DEA # \_\_\_\_\_

**PRINT OR TYPE NAME AND ADDRESS OF EXAMINING PHYSICIAN**

\_\_\_\_\_

**PHYSICIAN'S SIGNATURE [REQUIRED]**

\_\_\_\_\_

DATE



STUDENT NAME [FIRST & LAST]

DOB

## TUBERCULOSIS RISK ASSESSMENT FORM

THIS QUESTIONNAIRE MUST BE COMPLETED BY PARENT/GUARDIAN ANNUALLY

Parents, please complete this form on [secure.magnushealthportal.com](https://secure.magnushealthportal.com). If you answer yes to any questions, the medical evaluation for latent tuberculosis form must be completed by your healthcare provider.

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR STUDENT:

Has the student ever had a positive Tuberculosis test?

Yes  No

Was the student born or have they lived in a high-risk area for incidence of TB: Africa, Eastern Europe, Asia, Middle East, Central/South America, Russia?

Yes  No

Has the student traveled to any of these areas: Africa, Eastern Europe, Asia, Middle East, Central/South America, Russia in the past year?

Yes  No

Has the student ever had close contact with someone diagnosed with Tuberculosis?

Yes  No

Is the student's immune system compromised [such as receiving treatment for cancer, on long term steroids, organ transplant recipient, HIV/AIDS]?

Yes  No

Has the student received the BCG immunization with the past year?

Yes  No

If you have answered yes to any of these questions, the form Medical Evaluation for Latent Tuberculosis Form must be downloaded and completed by a healthcare provider. Please download the Medical Evaluation form for your healthcare provider and upload completed form to the Magnus Health Portal [[secure.magnushealthportal.com](https://secure.magnushealthportal.com)].

IF YOU HAVE ANSWERED NO TO ALL OF THESE QUESTIONS NO FURTHER ACTION IS REQUIRED.



STUDENT NAME [FIRST & LAST]

DOB

### MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

REQUIRED FOR ALL INTERNATIONAL STUDENTS. FOR DOMESTIC STUDENTS, MUST BE COMPLETED BY HEALTHCARE PROVIDER IF ANY YES ANSWERS ON PARENT'S QUESTIONNAIRE. PLEASE NOTE: IF A PATIENT HAS HAD A POSITIVE TUBERCULIN SKIN TEST IN THE PAST, DO NOT REPEAT THE TEST. GO TO SECTION B BELOW.

#### A. Tuberculin Testing [Mantoux / Intermediate PPD or Interferon Gamma Release Assay [IGRA] within the last 12 months]

1. **Mantoux** Please note: Mantoux test must be read by a healthcare provider 48-72 hours after administration. If no induration, mark "0". Results of multiple puncture tests, such as Tine or Mono – Vac are NOT accepted.

Date administered \_\_\_\_/\_\_\_\_/\_\_\_\_ Date test redone \_\_\_\_/\_\_\_\_/\_\_\_\_ Result \_\_\_\_ mm of induration

**Interpretation Of Tuberculin Skin Test** Please use table below and check response  Negative  Positive

Risk Factor	Positive result	
Close contact with a case of TB	5 mm or more	
Born in a country with a high rate of TB	10 mm or more	
Traveled/ lived for 1+ months in a country with high TB rates		10 mm or more
No risk factors [test not recommended]	15 mm or more	

**OR**

#### 2. Interform Gamma release Assay [IGRA]

Method used  QFT-G  Tspot Date obtained \_\_\_\_/\_\_\_\_/\_\_\_\_

Result [please check appropriate response]  Negative  Positive  Intermediate  Borderline

#### B. Positive skin test or positive IGRA requires a chest x-ray [Mantoux / intermediate PPD or IGRA tests]

1. Date of Positive test \_\_\_\_/\_\_\_\_/\_\_\_\_ Testing method  Mantoux  IGRA  Chest X-Ray  Normal  Abnormal

PLEASE ATTACH A COPY OF THE REPORT [NO DISCS OR FILMS]

Describe \_\_\_\_\_

2. Clinical Evaluation  Normal  Abnormal

Describe \_\_\_\_\_

3. Treatment  Yes  No Meds, Dose, Frequency, Dates: \_\_\_\_\_