1814

Dear Parent or Guardian,

On behalf of Linsly Health Services, welcome to the Linsly family! Health Services utilizes a healthcare management system called Magnus Health SMR (Student Medical Record) to collect and maintain all student based health information such as physical exams, medication administration forms and emergency contacts. As this is a web-based system, you will have continuous access to your child's health record as well as the ability to make updates when needed. Parents/guardians of officially enrolled students can access Magnus Health directly from your Veracross parent portal. Once you are logged in to the portal, you simply click the orange Magnus Health button on the right side of the screen.

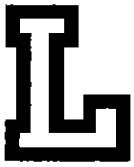
You will be granted access to Magnus Health **in early July** as long as we have received and processed your enrollment deposit and have received your Veracross login information. You can access your Magnus Health SMR account through The Linsly School website. Once on the Linsly homepage, select the "*Student Life*" tab on the top of the page. On the dropdown menu, you will select "*Health Services.*" On the Health Services page you will discover our hours of operation, contact information as well as the documents required ***prior*** to admission. If your child will be playing fall athletics, it is ***mandatory*** to have your Magnus account completed prior to the start of practices. If your child's Magnus account is not complete and we do not have a current (less than 1 year) physical exam on file, with both parent and physician signatures, your child will not be allowed to practice. To log on to your Magnus account, you will scroll to "*Annual Requirements*" and click on the bold type hyperlink "**Magnus Health HMR**" Your Magnus username and password will be the same as your Veracross account username and login. The first time you log in, you will be prompted to watch an introductory video that shows you how to use the system.

With Magnus Health, you should not turn in or have any paper health forms faxed to the school. All forms that require a physician signature can be printed from your Magnus Student Health Tracker. Completed forms can be scanned and then uploaded from your computer to Magnus Health. Another convenient option is the **Magnus Mobile** app which allows users to complete all requirements, including uploading photos of forms from a "smart device" such as a tablet or phone. More information regarding the mobile app can be found on the following link:

https://community.magnushealth.com/s/article/New-Magnus-Health-Mobile-App-Quick-Start-Guide

For your information and preparation, below is a list of items that may be on your Magnus Student Tracker:

- **Vital Health Record -** (health history, emergency contacts, health insurance information)
- **Physical Examination Form** - *(Note: Exams over 1 year old will not satisfy this requirement.)*
- **Immunization Form -** complete childhood record required
- **Medical Authorization and Consent to Treat Form**
- **Over-the-counter Medication Form**
- **Prescription Medication Form** if applicable. Printable and requires MD, DO, PA, or NP signature
- **Asthma Action Plan** if applicable. Printable and requires MD, DO, PA, or NP signature
- **Allergy Action Plan** if applicable. Printable and requires MD, DO, PA, or NP signature



- **School Diabetes Plan** if applicable. Printable and requires MD, DO, PA, or NP signature
- **Seizure Action Plan** if applicable. Printable and requires MD, DO, PA, or NP signature
- **Boarding student health insurance forms** if applicable. Printable and requires MD, DO, PA, or NP signature
- **Other school documents including technical use agreements or boarding specific forms.**

Please ensure that all documents, including immunizations, are translated to English.

You will find a copy of our Allergy Action Plan and Asthma Action Plan (if applicable) in your packet. Please email the office at healthservices@linsly.org to request additional applicable plans from the list above, if needed. The same plans will be available for you to print once you log into your Magnus account in July. Please reserve at least 20 minutes per child to complete your requirements. During the summer months, you will receive weekly email reminders if there are outstanding items in your account. So that we can be fully prepared for the start of school, please complete all of the requirements in your student's Magnus Health account and upload all documents by **July 24, 2025**.

Students who participate in pre-season sports **must** be up to date on their immunizations, boarding students must have proof of insurance documented, a current physical examination (less than 1 year) and current prescription (less than one year) for eyeglasses and/or contacts and a signed Medical Authorization and Consent to Treat form in Magnus Health in order to attend practice or compete in scrimmages or games.

Your student will not participate in practices, scrimmages or competition without a completed Magnus account, including a current physical examination (less than 1 year) and a signed Medical Authorization and Consent.

Wishing you a safe, healthy and enjoyable summer. If you have student specific questions or concerns, please contact us at healthservices@linsly.org. We will check our email weekly after June 14, 2025.

Magnus Health Questions or Problems?
If you are having difficulty navigating the Magnus system, entering data online, or downloading the hardcopy cover sheets and forms, or if you have any other questions, please contact customer support at Magnus Health SMR by phone at **877.461.6831** or by email at service@magnushealthportal.com.

Also, please feel free to consult the Magnus Health Privacy and Security page at www.magnushealth.com/privacy-and-security/

Enclosure: *WVSSAC Physical Examination Form, **Immunization Form, **Medication Order Form, **Allergy Action Plan and **Asthma Action Plan.

* Completed by a physician and parent
** Completed by a physician only

WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION

Revised 6/23

2875 Staunton Turnpike - Parkersburg, WV 26104

ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICIAN'S CERTIFICATE FORM

(Form required each school year on or after May 1st. File In School Administration Office)

ATHLETIC PARTICIPATION / PARENTAL CONSENT

PART I

Name _____ School Year:_____Grade Entering:_____

Home Address:_____ Home Address of Parents: _____

City: _____ City: _____

Phone: _____Date of Birth: _____ Place of Birth: _____

Last semester I attended _____(High School) or (Middle School). We have read the condensed eligibility rules of the WVSSAC athletics. If accepted as a team member, we agree to make every effort to keep up school work and abide by the rules and regulations of the school authorities and the WVSSAC.

INDIVIDUAL ELIGIBILITY RULES

Attention Athlete! To be eligible to represent your school in any interscholastic contest, you:

_____ must be a regular bona fide student in good standing of the school. (See exception under Rule 127-2-3)
_____ must qualify under the Residence and Transfer Rule (127-2-7)
_____ must have earned at least 2 units of credit the previous semester. Summer School may be included. (127-2-6)
_____ must have attained an overall "C" (2.00) average the previous semester. Summer School may be included. (127-2-6)
_____ must not have reached your 15th (MS), 19th (HS) birthday before July 1 of the current school year. (127-2-4)
_____ must be residing with parent(s) as specified by Rule 127-2-7 and 8.
  _____ unless parents have made a bona fide change of residence during school term.
  _____ unless an AFS or other Foreign-Exchange student (one year of eligibility only).
  _____ unless the residence requirement was met by the 365 calendar days attendance prior to participation.
_____ if living with legal guardian/custodian, may not participate at the varsity level. (127-2-8)
_____ must be an amateur as defined by Rule 127-2-11.
_____ must have submitted to your principal before becoming a member of any school athletic team Participation/Parent Consent/Physician Form, completely filled in and properly signed, attesting that you have been examined and found to be physically fit for athletic competition and that your parents consent to your participation. (127-3-3)
_____ must not have transferred from one school to another for athletic purposes. (127-2-7)
_____ must not have received, in recognition of your ability as a HS or MS athlete, any award not presented or approved by your school or the WVSSAC. (127-3-5)
_____ must not, while a member of a school team in any sport, become a member of any other organized team or as an individual participant in an unsanctioned meet or tournament in the same sport during the school sport season (See exception 127-2-10).
_____ must follow All Star Participation Rule. (127-3-4)
_____ must not have been enrolled in more than (8) semesters in grades 9 to 12. Must not have participated in more than six semesters in grades 6-8. (Rule 127-2-5).
_____ qualify under homeschool rule. (Rule 127-2-3.11, 127-2-7.2k, 126-26-3.1.1k)

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above listed minimum standards but also all other standards set by your school and the WVSSAC. If you have any questions regarding your eligibility or are in doubt about the effect any activity or action might have on your eligibility, check with your principal or athletic director. They are aware of the interpretation and intent of each rule. Meeting the intent and spirit of WVSSAC standards will prevent athletes, teams, and schools from being penalized.

PART II - PARENTAL CONSENT

In accordance with the rules of the WVSSAC, I give my consent and approval to the participation of the student named above for the sport NOT MARKED OUT BELOW:

BASEBALL	CROSS	GOLF	SWIMMING	VOLLEYBALL
BASKETBALL	COUNTRY	SOCCER	TENNIS	WRESTLING
CHEERLEADING	FOOTBALL	SOFTBALL	TRACK	BAND

MEDICAL DISQUALIFICATION OF THE STUDENT-ATHLETE / WITHHOLDING A STUDENT-ATHLETE FROM ACTIVITY

The member school's team physician has the final responsibility to determine when a student-athlete is removed or withheld from participation due to an injury, an illness or pregnancy. In addition, clearance for that individual to return to activity is solely the responsibility of the member school's team physician or that physician's designated representative.

I understand that participation may include, when necessary, early dismissal from classes and travel to participate in interscholastic athletic contests. I will not hold the school authorities or West Virginia Secondary School Activities Commission responsible in case of accident or injury as a result of this participation. I also understand that participation in any of those sports listed above may cause permanent disability or death. Please check appropriate space: He/She has student accident insurance available through the school ( ); has football insurance coverage available through the school ( ); is insured to our satisfaction ( ).

I also give my consent and approval for the above named student to receive a physical examination, as required in Part IV, Physician's Certificate, of this form, by an approved health care provider as recommended by the named student's school administration.

I consent to WVSSAC's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices or Scrimmages and Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

I have read/reviewed the concussion and Sudden Cardiac Arrest information as available through the school and at WVSSAC.org. (Click Sports Medicine)

Date: _____Student Signature_____Parent Signature_____

PART III – STUDENT'S MEDICAL HISTORY
(To be completed by parent or guardian prior to examination)

Name _____ Birthdate ____/____/____ Grade _____ Age _____

Has the student ever had:

Yes No 1. Chronic or recurrent illness? (Diabetes, Asthma, Seizures, etc.,)
Yes No 2. Any hospitalizations?
Yes No 3. Any surgery (except tonsils)?
Yes No 4. Any injuries that prohibited your participation in sports?
Yes No 5. Dizziness or frequent headaches?
Yes No 6. Knee, ankle or neck injuries?
Yes No 7. Broken bone or dislocation?
Yes No 8. Heat exhaustion/sun stroke?
Yes No 9. Fainting or passing out?
Yes No 10. Have any allergies?
Yes No 11. Concussion? If Yes _____ Date(s)
Yes No 12. Have any problems with heart/blood pressure?
Yes No 13. Has anyone in your family ever fainted during exercise?
Yes No 14. Take any medicine? List _____
Yes No 15. Wear glasses ___, contact lenses___, dental appliances___?
Yes No 16. Have any organs missing (eye, kidney, testicle, etc.)?
Yes No 17. Has it been longer than 10 years since your last tetanus shot?
Yes No 18. Have you ever been told not to participate in any sport?
Yes No 19. Do you know of any reason this student should not participate in sports?
Yes No 20. Have a sudden death history in your family?
Yes No 21. Have a family history of heart attack before age 50?
Yes No 22. Develop coughing, wheezing, or unusual shortness of breath when you exercise?
Yes No 23. (Females Only) Do you have any problems with your menstrual periods.

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several Days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge.	0	1	2	3
Not being able to stop or control worrying.	0	1	2	3
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

A sum of >3 is considered positive on either subscale (Question 1 and 2 or Questions 3 and 4) for screening purposes.

I also give my consent for the physician in attendance and the appropriate medical staff to give treatment at any athletic event for any injury.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE ____/____/____

PART IV – VITAL SIGNS

Height _____ Weight _____ Pulse _____ Blood Pressure _____
Visual acuity: Uncorrected ____/____; Corrected ____/____; Pupils equal diameter: Y N

PART V – SCREENING PHYSICAL EXAM

This exam is not meant to replace a full physical examination done by your private physician.

Mouth:			Respiratory:			Abdomen:		
Appliances	Y	N	Symmetrical breath sounds	Y	N	Masses	Y	N
Missing/loose teeth	Y	N	Wheezes	Y	N	Organomegaly	Y	N
Caries needing treatment	Y	N	Cardiovascular:					
Enlarged lymph nodes	Y	N	Murmur	Y	N			
Skin - infectious lesions	Y	N	Irregularities	Y	N			
Peripheral pulses equal	Y	N	Murmur with Valsalva	Y	N			

Any "YES" under Cardiovascular requires a referral to family doctor or other appropriate healthcare provider.

Musculoskeletal: (note any abnormalities)

Neck:	Y	N	Elbow:	Y	N	Knee/Hip:	Y	N	Hamstrings:	Y	N
Shoulder:	Y	N	Wrist:	Y	N	Ankle:	Y	N	Scoliosis:	Y	N

RECOMMENDATIONS BASED ON ABOVE EVALUATION:

After my evaluation, I give my:

_____ Full Approval;

_____ Full approval; but needs further evaluation by Family Dentist ____; Eye Doctor ____; Family Physician _____; Other ____;

_____ Limited approval with the following restrictions: _____;

_____ Denial of approval for the following reasons: _____.

_____ ____/____/____

MD/DO/DC/Advanced Registered Nurse Practitioner/Physician's Assistant Date

The Linsly School — Immunization Record

Immunization history to be completed by a licensed caregiver

Parents/Guardians: Please upload all forms to Magnus Health

Student Name: _____ **Date of Birth:** ____/____/____ **Gender:** _____
Last First

Student Type: New___ Returning___ **(Returning Students** only provide immunizations received during previous year)

Per West Virginia State Code Section 64CSR95 *Immunization Requirements and Recommendations for School Children*, "Children who are delinquent for any required vaccinations, or who have exceeded the provisional enrollment period, will be considered to be out of compliance with the law and are required to stop attending school until the appropriate vaccine(s) or laboratory evidence is received and the records are amended." Regardless of residency, students must comply with these state laws if they attend school in the state of West Virginia.

The following requirements must be fulfilled prior to arrival on campus.

Vaccine	West Virginia State Requirement
Dtap/DTP/Td/Tdap	4 doses required. One dose must be after the 4th birthday.
Tdap booster	Proof of additional booster required for 7th grade
Polio (IPV)	3 doses required. If series includes both OPV/IPV then 4 doses required. One dose must be after the 4th birthday.
Measles, Mumps and Rubella (MMR)	2 doses required. First dose must be after the 1st birthday.
Varicella	2 doses required. First dose must be after the 1st birthday.
Hepitatis B	3 doses required. Last dose must be after the age of 6 months.
Meningococcal/meningitis (MCV4)	1 dose required for entry into 7th grade. For 12th grade, 1 dose required if received after 16th birthday. 2 doses required if first dose was before 16th birthday.

Immunization	Record Completed Dates (month/day/year)				
Dtap/DTP/Td/Tdap*	1	2	3	4	5
Tdap booster* (7th grade)	1				
Polio (indicate IPV/OPV)*	1	2	3	4	
Measles, Mumps and Rubella (MMR)*	1	2	Serological Confirmation of Measles Immunity: Serological Confirmation of Rubella Immunity:		
Varicella*	1	2	Date of Varicella Disease or Serological Confirmation of Varicella Immunity:		
Hepatitis B*	1	2	3		
Meningococcal/meningitis (MCV4)* (7th and 12th grade)	1	2			
Meningococcal B (Trumenba, Bexsero)	1	2			
Human Papilloma Virus (HPV)	1	2	3		
Hepatitis A	1	2	3		
Coronavirus 2019 Manufacturer: _____	1	2			

* Per West Virginia State law, full immunization schedule is required before student can attend school or reside on campus

I certify that this child is appropriately immunized according to the above West Virginia State requirements.

Physician/Provider Signature: _____ **Date:**____/____/____

Linsly School Health Services - Email: healthservices@linsly.org - Phone: 304-234-4612 X500 - Fax: 304-232-1975

Medication Orders to be completed by a licensed caregiver

Parents/Guardians, Please upload all forms to Magnus Health

Student Name: _____ **Date of Birth:** ____/____/____ **Gender:** _____
Last First

Allergies: _____

Medication Orders to be administered to student:

Medication Name	Dose	Route	Time	Is this a New Medication?
Start Date: / / End Date: / /			__Breakfast __Lunch __Dinner __Bedtime __As Needed __Other:_____	☐ Yes ☐ No
Condition for which this medication is prescribed or special instructions:				
Start Date: / / End Date: / /			__Breakfast __Lunch __Dinner __Bedtime __As Needed __Other:_____	☐ Yes ☐ No
Condition for which this medication is prescribed or special instructions:				
Start Date: / / End Date: / /			__Breakfast __Lunch __Dinner __Bedtime __As Needed __Other:_____	☐ Yes ☐ No
Condition for which this medication is prescribed or special instructions:				

I have completed/reviewed the above medication orders and I understand that my signature authorizes Linsly Health Staff to administer such medication(s).

Physician/Provider Signature: _____ **Date:** ____/____/____

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

BOARDING STUDENTS ONLY:

The Linsly School has partnered with Reisbeck's pharmacy in St. Clarisville, Ohio for prescription delivery, refills and unit dose packaging of all BOARDING STUDENT medications. Physicians are asked to call in, fax or mail prescriptions to:

Reisbeck's Pharmacy Store #7
104 Plaza Drive
St. Clairsville, OH 43950
Phone: 740-695-0274
Fax: 740-695-2412
NPI: 1598764086

Parents are asked to call the store to complete student registration 3 weeks prior to the start of school. Prescription / Health insurance information and a form of payment for any co-pays or deductibles are required to complete registration.

Prescriptions written by a physician outside the United States will require coordination with our school physician for a United States based prescription. Please email the school nurse to schedule a consultation.

The Linsly School — Asthma Action Plan

This plan provides student specific guidance to Linsly personnel in the event that a student with known asthma needs urgent/emergency care. This form may be shared with any Linsly personnel involved in student care.

Student Name: _____ Date of Birth: ____/____/____
Last First

Grade: _____ Weight: _____ Gender (circle): M F For School Year Beginning: 20_____

Additional Health Concerns: _____

Allergies: _____

Student Specific Asthma Signs:

Usual signs of student's asthma:

__ Wheeze __Tight Chest __ Cough __Difficulty breathing __Difficulty talking __ Other_____

Signs student's asthma is getting worse:

__ Wheeze __Tight Chest __ Cough __Difficulty breathing __Difficulty talking __ Other_____

Student's asthma Triggers

__Cold/Flu __ Exercise __ Smoke __ Pollens __Dust __ Other_____

Asthma Medication Requirements:

Name of Medication (Ex: Flovent, Pulmacort)	Method / Route (Ex: Inhaler, Inhaler with spacer)	When and how much? (Ex: 1 puff every morning and night, before exercise)

Does the student need assistance taking his/her medication? __Yes __No If yes, How?_____

Asthma First Aid Plan:

If student experiences any of the above symptoms or indicates that he/she is having trouble breathing:

1. Have student stop activity and sit upright. Be calm/reassuring and do not leave student alone
2. Assist student with medication administration if needed
3. Allow student to repeat medication dose if symptoms do not improve after _____ minutes
4. If no improvement or <u>if symptoms worsen,</u> **Call 911**. Tell operator that student is having an asthma attack and that emergency/rescue medication has been administered.
5. Call School Nurse (Linsly Extension 500)
6. Emergency Contact:_____ Phone: ( ) _____

I give permission for this information to be shared with Linsly personnel who are in contact with my child through any school, sporting events or extra-curricular activities where an asthma related emergency could occur. ___Yes ___No

Parent/Guardian Signature: _____ Date ____/____/____

- ☐ This student has received instruction on the proper use of an emergency inhaler. It is my professional opinion that this student SHOULD be allowed to carry and use the inhaler independently.
- ☐ It is my professional opinion that this student SHOULD NOT carry an emergency inhaler. It will be stored in an agreed upon designated location in the school. LOCATION: __ Health Office __ Main Office __ Other:_____

Physician's Signature: _____ Date ____/____/____

Linsly Health Services - Email: healthservices@linsly.org - Ph: 304-234-4612 X500 - Fax 304-232-1975

The Linsly School — Allergy Action Plan

This plan provides student specific guidance to Linsly personnel in the event that a student with known allergies needs urgent/emergency care. This form may be shared with any Linsly personnel involved in student care.

Student Name: _____ Date of Birth: ____/____/____ School Year: 20____
Last First

Grade: _____ Weight:_____ Does student have Asthma? *Yes____ No____ *higher risk for severe reaction

ALLERGY TO: _____

Additional Health Concerns: _____

Physician Authorized Treatment:

If food ingested or contact with allergen occurs*:	**Give checked medication (s):**
If a food allergen has been ingested, but no symptoms:	__ Epinephrine __ Antihistamine __ Observe for other symptoms
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	__ Epinephrine __ Antihistamine
Nose: Itchy, Runny, sneezing	__ Epinephrine __ Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	__ Epinephrine __ Antihistamine
Gut/GI: Nausea, abdominal cramps, vomiting, diarrhea	__ Epinephrine __ Antihistamine
+Throat: Tightness of throat, hoarseness, hacking cough	__ Epinephrine __ Antihistamine
+Lung: Shortness of breath, repetitive coughing, wheezing	__ Epinephrine __ Antihistamine
+Heart: Thready pulse, low blood pressure, fainting, pale, blueness	__ Epinephrine __ Antihistamine
+Other: _____	__ Epinephrine __ Antihistamine
If reaction is progressing OR **>1**of the above areas is affected	__ Epinephrine __ Antihistamine

*The severity of the symptoms can quickly change. + Potentially life-threatening.

Medications / Dosages:

Epinephrine Brand: _____ **Epinephrine Dose: 0.15mg IM ____ OR 0.3mg IM____**

Antihistamine Brand: _____ **Antihistamine Dose:** _____

Other (e.g. inhaler/bronchodilator): _____
List medication name/dose/route

Emergency Phone Calls:

1. **Call 911** - State that an allergic reaction has occurred, treatment has been administered and additional epinephrine may be needed.
2. Call the School Nurse (Linsly Extension 500)
3. Emergency Contact:_____ Phone: ( ) _____

I give permission for this information to be shared with Linsly personnel who are in contact with my child through school, sporting events or extra-curricular activities where an allergic reaction could occur. ___Yes ___No

Parent/Guardian Signature: _____ Date ____/____/____

- ☐ This student has received instruction on the proper use of an epinephrine pen. It is my professional opinion that this student SHOULD be allowed to carry and use the Epinephrine pen independently. The student knows when to request antihistamine and has been advised to inform a responsible adult if the epinephrine pen is self-administered.
- ☐ It is my professional opinion that this student SHOULD NOT carry an Epinephrine pen. It will be stored in an agreed upon designated location in the school. LOCATION: __ Health Office __ Main Office __ Other:_____

Physician's Signature: _____ Date ____/____/____

Linsly Health Services - Email: healthservices@linsly.org - Ph: 304-234-4612 X500 - Fax 304-232-1975