The Putney School SUMMER ARTS
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2017 EMERGENCY INFORMATION & PERMISSION TO TREAT

(completed by parent/guardian)

Student Name: _____ Date of Birth: _____ month/day/year

Primary Language: _____Nickname: _____

Sex: Female Male Gender Identity: _____

Last Tetanus: _____ Allergies: _____

Medical History/Info: _____

Medications: _____

Primary physician: _____Phone: _____

PERMISSION TO TREAT: We/I _____ **(parent name)** hereby give permission to The Putney School and its authorized agents in the pursuit of prevention and/or event of illness or accident to our/my child, _____ (**student name**), to secure medical, mental health, reproductive health, dental, or surgical services/treatment for him/her. We hereby give permission and authorize THE PUTNEY SCHOOL, its authorized personnel or agents, and those physicians, practitioners, surgeons, and dentists enlisted by the school, to give, administer, and render any treatment or aid, including anesthesia or surgery, as necessary to protect, preserve and safeguard our/my child's life and/or health. We/I further authorize The Putney School through its Health Services personnel to release information to facilitate the medical or surgical care of our/my child and, as is necessary, to facilitate the release of information for the completion of a claim for health insurance. We/I release The Putney School from any financial responsibility for the above-referenced treatment.

USE/ DISCLOSURE INFORMATION: This form authorizes Health Services, counseling staff and community health care providers to whom the student is referred for health care to use and disclose to each other the student's health information in order to evaluate whether accommodations at school are recommended or necessary in order to address the student's health-related condition and/or to provide the student's health information to school administration including the head of school to the extent necessary to make their above mentioned recommendation. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that you be informed that, by signing this form, you authorize the use/disclosure of the student's health information as described above. This authorization shall become effective immediately and remain for one year following the child's last day of attendance. You have the right to revoke this authorization at any time. Revocation must be in writing, signed by a parent/guardian and delivered to Health Services. I understand that The Putney School will protect the student's health information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's health record. The information will be shared with individuals working at or with The Putney School for the purpose of providing safe and appropriate health care for the student.

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Person responsible for payment: _____

Home address: _____

_____

City State/Country Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

Alternate Emergency Contact & Number/Email: _____

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2017 STUDENT HEALTH INSURANCE COVERAGE

Student Name: _____

Student Date of Birth: _____

Insurance Carrier: _____

Group/ID Number: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Notes (e.g. - preauthorization required, no Urgent Care coverage, etc.): _____

Please attach a legible photo copy of the FRONT of the insurance card in the space below:

FRONT OF CARD

Please attach a legible photo copy of the BACK of the insurance card in the space below:

BACK OF CARD

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2017 STUDENT HEALTH HISTORY

(completed by parent/guardian)

Student Name: _____ Date of Birth (month/day/year): _____

Drug Allergies: _____ ❑ No Known Drug Allergies

Other Allergies: _____

Epi-pen: Yes/No Inhaler: Yes/No

Please note that it is recommended that students bring two epi-pens and/or inhalers; one to have on them, one to store in Health Services.

Current Medications: _____

(in addition to listing here, please have prescriber fill out the Prescription Medication Instructions)

Does or has your child ever:	YES	NO	If yes, please explain and include dates
Had an ongoing medical condition?	❑	❑	
Seen a medical specialist?	❑	❑	
Had an allergic reaction?	❑	❑	❑food ❑environmental ❑insect ❑medication ❑ other
Been hospitalized or had surgery?	❑	❑	
Had a concussion or serious head injury?	❑	❑	
Lost consciousness or "passed out"?	❑	❑	
Had a seizure/epilepsy?	❑	❑	
Been identified or treated for substance abuse?	❑	❑	
Exhibited suicidal tendencies?	❑	❑	
Exhibited self-harming tendencies?	❑	❑	

Check all that apply to your child and provide details below:

❑ ADHD/ADD
❑ Anemia
❑ Anxiety
❑ Asthma (inhaler yes/no)
❑ Other: _____

❑ Chronic headaches/migraines
❑ Counseling
❑ Depression
❑ Eating/body image disorder
❑ Other: _____

❑ Severe menstrual cramps
❑ Seasonal allergies
❑ Sleep difficulties
❑ Stomachaches/digestive issues
❑ Other: _____

Notes on items checked above:_____

_____

(continue on back)

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Student Name: _____

Vermont State Immunization Requirements for School Entrance/Attendance **(PLEASE PROVIDE DATES FOR THE FOLLOWING)**				
Diphtheria, Tetanus & Pertussis (DTap) - 5 doses required				
1	2	3	4	5
Tdap Booster - 1 dose required				
1				
Polio (IPV/OPV) - 4 doses required				
1	2	3	4	
Hepatitis B (Hep B) - 3 doses required				
1	2	3		
Measles, Mumps & Rubella (MMR) - 2 doses required				
1	2			
Varicella (Chickenpox) - 2 doses or date of disease (month & year) **required**				
1	2			
Meningococcal (Menactra - e.g.) - 1 dose required for boarders, 2 doses recommended for all				
1	2			
TB Skin Test (Mantoux/PPD) - required for all international students				
Date of Mantoux/PPD:		Interpretation: Positive / Negative		
Other Vaccination:				
Other Vaccination:				

My student is exempt from the following vaccinations: _____
I understand that I must provide a completed Vermont State Vaccination Exemptions Form ❑

Parent Signature: _____ Date**:** _____
By signing this form, I verify that this information is true and complete, to the best of my knowledge

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2017 AUTHORIZATION TO ADMINISTER MEDICATION

(completed by parent/guardian)

Student Name: _____Date of Birth: _____

Drug Allergies & Reaction: _____

MEDICATION POLICY

All medications, non-prescription or prescription, and/or supplements/vitamins must be reported to and approved by Health Services. Most prescription medications are administered by or through Health Services, and exceptions are at the discretion of Health Services. All medications should be sent direct to Health Services, not to the student. Each prescription medication must have a completed and signed Prescription Medication Instructions on file in Health Services. Prescription medications taken any time during the day are administered out of the Health Services office; prescription medications taken after 7:30pm are packed by a nurse and stored in a lock-box in the dorm, to be handed out by a dorm head. Students must take their medication in the presence of the administering adult.

MEDICATION POLICY AGREEMENT (ALL PARENTS/GUARDIANS)

I have read and understand the medication policy at The Putney School and agree to abide by its guidelines. I have reviewed the guidelines with my child. I understand that my child cannot possess any medication (over-the- counter, herbal, natural remedies, or prescription) without receiving permission from a school nurse. I am responsible for promptly updating Health Services with any changes in medications or as new medications are prescribed. I understand that discontinued medications, including dosage changes, will be disposed of through the Windham County Sheriff's Office within two weeks unless I make other arrangements with Health Services. I understand that violation of the medication policy may result in a disciplinary hearing for my child.

Parent/guardian initials _____

PRESCRIPTION MEDICATION ADMINISTRATION CONSENT (ALL PARENTS/GUARDIANS)

I give permission for Health Services or school personnel designated by Health Services to administer prescription medications prescribed to my child. These medications may include prescriptions my child is currently on or medication prescribed while my child is at school. Prescription medications from home must be accompanied by Prescription Medication Instructions signed by the prescribing caregiver. I understand that Prescription Medication Instructions are required for every change in a prescribed medication's administration. I understand that all prescription medication must be kept in its original pharmacy container with the appropriate label specifying student name, medication, dosage, route, and frequency or time of administration, and other special instructions.

Parent/guardian initials _____

OVER-THE- COUNTER MEDICATION ADMINISTRATION (ALL PARENTS/GUARDIANS)

I give permission for Health Services or school personnel designated by Health Services to administer standard over-the- counter medications (exclusions noted below) to my child according to guidelines approved by the school physician. **Parent/guardian initials _____**

Exclusions: _____

PARENTAL CONSENT FOR SELF-ADMINISTRATION OF MEDICATION (ALL PARENTS/GUARDIANS)

I give permission for my child, at the discretion of Health Services, to self-administer a specified medication. I feel comfortable that my child can responsibly administer their own medications. The Putney School can provide support and teaching to students taking medication, but does not assume responsibility for students who self-administer medications (prescription, over the counter, or natural/herbal remedies) as prescribed by a physician. The option for self-administration excludes all controlled substances, which must be stored according to school policy and administered by Health Services or school personnel designated by Health Services. **Parent/guardian initials _____**

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION (ALL STUDENTS)

1. I have read the medication policy and will abide by its guidelines.
2. I understand that I am responsible for taking medications as directed, including going to Health Services during the day or contacting my dorm head in the evening.
3. I will report lost medication to Health Services immediately.
4. I agree to contact an adult on campus if I do not feel well, or if I have a question about my medication.
5. I agree to NEVER share or sell my medication with or to anyone.
6. I agree to NOT keep medications in my dorm room or with me unless authorized to do so by Health Services.
7. I understand that not following these guidelines may result in a disciplinary process. **Student initials _____**

Student signature: _____ Parent/guardian signature: _____

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2017 CONCUSSION ACTION PLAN

(completed by parent/guardian and student)

Student Name: _____ Date: _____

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells. Medical providers may describe a concussion as a "mild" brain injury because concussions are usually not life-threatening. Even so, the effects of a concussion can be serious (CDC Jan '17).

The goal of the concussion protocol is to ensure that concussed students are identified, treated and referred appropriately for return-to-learn and return-to-play. When a student sustains impact to or hits their head, a nurse does a concussion assessment, including neurological check and documentation of self-reported symptoms. In most cases, students do not need to go to the doctor or emergency department. The plan for recovery is student-driven, with accommodations made to address symptoms and maximize recovery. Following concussion, no matter how mild, students are expected to report daily to Health Services to complete a concussion symptom questionnaire that allows for objective assessment of student's recovery until symptom-free.

Recognition of Concussion

<u>These signs and symptoms – following a witnessed or suspected blow to the head or body – are indicative of a probable concussion.</u>

Forgets plays	Headache
Appears dazed or stunned	Fatigue
Exhibits confusion	Nausea or vomiting
Unsure about game, score, opponent	Double vision, blurry vision
Moves clumsily (altered coordination)	Sensitive to light or noise
Balance problems	Feels sluggish
Personality change	Feels "foggy"
Responds slowly to questions	Problems concentrating
Forgets events prior to hit	Problems remembering
Forgets events after the hit	Loss of consciousness (not required)

Any student who exhibits signs, symptoms, or behaviors consistent with a concussion will be removed from competition or practice and will not be allowed to train or compete with a school athletic team or physical activity until the student has been examined by and received written permission to participate in athletic activities from a health care provider (per Act 68, approved by the VT Legislature in 2013).

The registered nurse on duty and/or the coach has been designated to make the initial decision to remove a student from play when it is suspected the athlete may have suffered a concussion. Athletes with a suspected concussion should not be permitted to drive home. A member of the Health Services team informs parents/guardians that their student/child may have sustained a concussion.

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Return-to-Learn Protocol: In cases of severe concussion, the following steps are required before the student can return to academic activity. The student is required to complete the RTL protocol and be symptom free for 24 hours before beginning the RTP protocol.

Home - Total Rest
Home - Light Mental Activity
School - part time – maximum accommodations: short days, scheduled breaks, modified testing and assignments
School - part time – moderate accommodations: modified testing, increase time in classroom
School - full time – minimal accommodations: routine testing, increase time in classroom
School - full time – full academics, no accommodations

Return-to-Play Protocol: The return-to-play plan should start only when student has been without any symptoms for 24 hours. It is important to wait for 24 hours between steps because symptoms may develop several hours after completing a step. Do not take any pain medications while moving through this plan (no ibuprofen, aspirin, Aleve, or Tylenol). This program is supervised by Putney's coaches under the guidance of Putney's sports nurse.

Step 1: Aerobic conditioning - walking or stationary cycling.
Step 2: Sports-specific, simple, non-contact drills – skating drills in hockey, running drills in soccer/basketball.
Step 3: Non-contact training drills – more complex training drills - passing in soccer/ice hockey/basketball.
Step 4: Full contact practice.
Step 5: Full medical clearance for return to play.

Generally, Health Services nurses and/or the sports nurse approve a student's progress through the RTP steps, culminating in return to play. Health Services staff reserve the right to defer to the school's consulting physician or the student's home physician to make the final determination regarding the student's return to athletic activity.

Student & Parent Acknowledgement

We have received and read concussion information provided to us by The Putney School. I understand the information provided and agree to the following:

1. To report any concussion or concussion-like symptoms that occurs as a result of injury outside of school.

2. (Student) To report any concussion or concussion-like symptoms that occurs while at school.

3. (Student) To report daily to Health Services daily for assessment until symptom-free; return to play is contingent on one week symptoms-free as documented on the daily concussion symptom questionnaire.

4. We understand that medical clearance after a concussive injury clears the student to start the return to physical activity protocol - not to immediately return to full participation.

Student signature: _____ Date: _____

Parent Signature: _____ Date: _____

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2017 PHYSICAL EXAMINATION

(completed by health care provider)

Student Name: _____ **Date of Birth**: _____

Drug Allergies & Reaction: _____

Other Allergies & Reaction: _____

Epi-pen and/or inhaler? _____

Current Medications (in addition to listing here, please complete Prescription Medication Instructions form):

_____

Is there any condition that would prevent this child from participating in sports or other physical activities?
No/unrestricted Yes/restricted: _____

Vital Signs	
Height & Weight	

SYSTEM	WNL	COMMENTS AND/OR CONCERNS
HEENT		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Respiratory		
Musculoskeletal		
Neurological		

Please attach a copy of immunization records (or exemption form) and physical exam notes as needed.

I have reviewed this student's health information and performed a physical examination. To the best of my knowledge, this child is in good health and has no limitations to participation at The Putney School (other than those noted in previous notes on this form). Completed by a licensed medical practitioner not related to the student, within 6 months of beginning of school year.

Physician Signature: _____
Physician Name: _____
Address: _____
Phone Number: _____ **Fax Number:** _____

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2017 PRESCRIPTION MEDICATION INSTRUCTIONS

(completed by prescriber)

Prescription medication cannot be administered to a student until Health Services receives a completed and signed copy of this form. Medication must be in its original container, labeled by the pharmacy as prescribed by the prescriber. All regularly scheduled medications must be listed here and on the Emergency Information & Permission to Treat Form, so that, in the event of an emergency, the treating physician is aware of all medications. Please fill out instructions for each medication ordered. The Putney School requires a new form to be submitted each time there is a change in the medication, dosage, or administration.

Student Name:_____ Today's Date:_____

Date of Birth:_____ Epi-pen: ☐Yes ☐No Inhaler: ☐Yes ☐No

☐ Allergies: _____ ☐NKDA

Medication/Dosage	Directions	Reason for taking

Physician Name (print please): _____

Physician Signature: _____ Date: _____

Phone: _____ Email: _____

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2017 MENTAL HEALTH REPORT

(completed by health care provider)

Student Name: _____ Date of Birth: _____

To the Mental Health Professional: This student has already been accepted to The Putney School. In an effort to provide the most comprehensive services possible, it is important that we know of any emotional difficulties the student has had, should any mental health issues arise in our rigorous boarding school environment. Thank you for completing the following:

When and for how long did you see the student?

What were the presenting issues and the DSM V diagnosis?

What treatment was provided and how would you assess the outcome?

Was/is medication prescribed and if so, what?

List all hospitalizations related to mental health, including length of stay, date of discharge and reason for admission:

Please indicate if you would like Jessica Taylor, Counseling Coordinator, to contact you regarding this student. Best way to contact you:

email: _____

phone:_____

I verify that the information expressed here is as complete and true to my knowledge as possible.

Signature: _____ Date: _____

Please print name: _____

License, Title, Degree: _____

Phone and/or Email: _____

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