The Putney School SUMMER ARTS

418 Houghton Brook Road • Putney, VT • 05346

summernurse@putneyschool.org • (802) 387-6221 • f (802) 387-6228

Greetings from Health Services at The Putney School!

Student safety and wellbeing are our top priorities. To that end, health forms must be submitted for **ALL** Summer Programs students, new and returning. We ask you to complete all health forms with detail, accuracy and honesty. Please submit forms as soon as possible and within 30 days of notification of your child's acceptance. Our ability to prepare appropriately and care for your child is compromised by any delay.

Parents/guardians and students, complete and return within 30 days of acceptance:

- Emergency Information & Permission to Treat
- Student Health Insurance Coverage (students who are not covered by a health insurance policy issued in the United States are required to purchase a policy offered through the school's insurance provider)
- Student Health History
- Authorization to Administer Medication (parent/guardian and student)
- Concussion Policy (parent/guardian and student)

Physicians complete and return the following within 30 days of your child's acceptance:

- Physical Examination (can be an exam within the past 12 months) – MUST INCLUDE IMMUNIZATION RECORD (see requirements)
- Prescription Medication Order Form (mark and submit form N/A if no prescription medications)
- Mental Health Report completed by provider if any of the statements below apply to the student:
    1. The student has been seen by a mental health practitioner within the last year
    2. The student is currently on any medication for mental health
    3. The student has ever been hospitalized for mental health purposes
    4. The student will require special accommodations during their time at The Putney School Summer Arts (i.e. Skype sessions with their counselor)
    5. If none of these apply to your child, mark the report N/A, sign and return

After completion, please scan copies to summernurse@putneyschool.org, fax to 802.387.6228, or mail hard copies to:

The Putney School Health Services
418 Houghton Brook Rd
Putney, VT 05346

Our team looks forward to being a part of your child's time at Putney, whether in sickness or in health. Thank you for providing us the information to make that possible! If you have any questions, feel free to contact me at sdunbar@putneyschool.org or 802.387.6221.

Sara Dunbar, RN
Health Services Coordinator

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2019 EMERGENCY INFORMATION & PERMISSION TO TREAT

Student Name:____

Date of Birth:____________________ **Primary Language:**____________________ **Preferred Name:**____________________
month / day / year

Sex: ❑ **Female** ❑ **Male** ❑ **Non-binary** **Gender Identity:**________________ **Last Tetanus:**____________________

Allergies:____

Pertinent Medical History/Info:____

Medications:____

Primary physician:____ **Phone:**____________________

PERMISSION TO TREAT: We/I____(**parent/guardian name**) hereby give permission to THE PUTNEY SCHOOL and its authorized agents in the event of illness or accident to our/my child,________________________(**student name**), to secure medical, mental health, dental, or surgical services/treatment for him/her/them. 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:____

Address:____
Street City State Postal Code Country

Home Phone:______________________________ **Cell Phone:**______________________________

Email:____

Alternate Emergency Contact:

Name: ____

Phone Number: ________________________ **Email:** ______________________________

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2019 STUDENT HEALTH INSURANCE COVERAGE

Students who are not covered by a health insurance policy issued in the United States are required to purchase a policy offered through the school's insurance provider.

Student Name:______________________________

Student Date of Birth:______________________________

Insurance Carrier:______________________________

Group/ID Number:______________________________

Subscriber's Name:______________________________

Subscriber's Date of Birth:______________________________

Notes or limitations to coverage (eg 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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2019 STUDENT HEALTH HISTORY

Completed by parent / guardian. Please use following page as needed for additional information.

Student Name:______________________________ **Date of Birth (month/day/year):**____________________

Drug Allergies:____ ❑ **No Known Drug Allergies**

Other Allergies:____

Epi-pen: Yes/No **Inhaler: Yes/No** **Other Emergency Medication:** ______________________________

Please note that it is recommended that students bring at least 2 epi-pens/inhalers/etc. One to have with them, one to store in Health Services.

Current Medications: ____

(in addition to listing here, prescriber must complete and return Medication Order form)

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 the items checked above:____

____

Is there anything else we should know about your child's physical health, mental health, or learning needs in order to help them thrive at The Putney School Summer Arts? ____

____

By signing this form, I verify that the information expressed here is complete and true to the best of my knowledge.

Parent Signature:____ **Date:** ______________

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2019 STUDENT HEALTH HISTORY, Additional Information

Continued from previous page
Completed by parent / guardian

Student Name:________________________________Date of Birth (month/day/year): ____________________

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By signing this form, I verify that the information expressed here is complete and true to the best of my knowledge

Parent Signature:____**Date:** ____________

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2019 AUTHORIZATION TO ADMINISTER MEDICATION

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. Any medications sent during the summer should be sent directly to Health Services, not to the student. Each prescription medication must have a completed and signed Medication Order form 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, 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 a Medication Order form signed by the prescribing caregiver. I understand that a new Medication Order form is 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: ____ **Date:** ____________________

Parent/guardian signature: ____________________________________ **Date:** ____________________

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2019 CONCUSSION POLICY

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

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

Appears dazed or stunned	Fatigue
Exhibits confusion	Nausea or vomiting
Unsure about game, score, opponent	Double vision, blurry vision
Forgets plays	Headache
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 person 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.

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 or other strenuous activity.

Parent Signature: ____ Date: ____________________

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2019 PHYSICAL EXAMINATION

Exam by a licensed medical practitioner not related to student within 12 months

Student Name:____Date of Birth: ________________

Today's Date: _______________ Date of Exam: _________________

Drug Allergies: ____

Other Allergies: ____

Emergency Medication (epinephrine, inhaler, glucagon, etc)? ____

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

____

Vital Signs	
Height & Weight	

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

Is there any condition that would prevent this child from participating in sports or other physical activities?

NO/unrestricted YES/restricted: ____

Please attach a copy of any physical examination notes as needed.

Physician Name: _________________________________ Signature: _______________________________

continued

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REQUIRED IMMUNIZATIONS

Healthcare Provider Signature Required

Student Name ______________________________________ Date of Birth ______/______/____________
month/ day /year

All numbered areas are required to be completed by a healthcare provider AND comply with ACIP guidelines. All immunizations must be recorded on this form in a format that includes the month/day/year.

IMMUNIZATION	DATE ADMINISTERED (month/day/year)		
Tdap booster Pertussis-containing tetanus booster ***within last 10 years required for all students***	**1**		
Measles/Mumps/Rubella Combination Vaccine (MMR) 2 dose series OR lab evidence of immunity	**1**	**2**	Evidence of Immunity for all components:
Varicella (Chicken Pox) 2 dose series OR documentation of history of disease OR lab evidence of immunity	**1**	**2**	Evidence of Immunity: History of disease at age _______ years
Meningococcal (MCV4, MCV7) 2 dose series wuth 1st dose 11-12 yrs and booster after age 16 ***for all students living in campus housing***	**1**	**2**	

SIGNATURE of HEALTH CARE PROVIDER

Please attach a copy of this student's complete immunization record.

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 Summer Arts (other than those already noted on this form).

Health Care Provider Name ________________________________ **Signature**__________________________

Phone ______________________ Fax _________________________ E-mail ___________________________

Address ______________________________________ City _______________ State ________ Zip _______

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2019 PRESCRIPTION MEDICATION ORDER FORM

Prescription medications 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 medication, dosage, or administration.

Student Name:_______________________________________ **Date of Birth:**____________________

Epi-pen: ❑ Yes ❑ No. **Inhaler:** ❑ Yes ❑ No

❑ **Allergies:**____ ❑ **NKDA**

Medication Name & Dose	Frequency, Route, Time of administration & Instructions	Reason for Taking

Physician Name:____**Today's Date:**________________

Physician Signature:____

Phone:_________________________________**Email:**______________________________________

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2019 MENTAL HEALTH REPORT

Student Name:____ **Date of Birth:**____________________

To the Mental Health Professional: This student has already been accepted to The Putney School Summer Arts. 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 us 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: __________________________________ **Email:** __________________________________