The Putney School
SUMMER ARTS

Health Office, 418 Houghton Brook Rd • Putney, VT • 05346
summer.nurse@putneyschool.org • (802) 387-6221 • fax (802) 387-6228

2025 Healthcare Provider Forms

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, and submit them as soon as possible, and no later than the dates listed below. ***Any changes in health status or medications must be reported before arrival***. Our ability to prepare appropriately and care for your child may be compromised by any delay.

Healthcare Provider Forms to be returned to us no later than **May 15, 2025**:
☐ 1. Physical Examination (completed within the last 12 months)
☐ 2. Complete Immunization Record (see below if exempt)

If applicable: Healthcare Provider Forms to be returned to us no later than **May 15, 2025**:
☐ 3. Prescription Medication Order Form
☐ 4. Mental Health Provider Report
☐ 5. Immunization Religious Exemption Form **or** Medical Exemption Form

All forms require a **written signature**; electronic signatures are not accepted. When completed, please **retain a copy for your records** before scanning and emailing to summer.nurse@putneyschool.org.

If you have any questions, feel free to contact me at summer.nurse@putneyschool.org or call our office at (802) 387-6221.

Lauren Shockley, APRN, FNP-C
Director of Health Services

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2025 PHYSICAL EXAMINATION

Physical exam carried out by a licensed medical provider, not related to the student, within last 12 months

Student Name:		**Student DOB:**	
Today's Date:		**Date of Exam:**	
Drug Allergies:		**Other Allergies:**	

Emergency Medications: Epinephrine, inhaler, glucagon, etc	
Current Medications:	Please complete below Med Order Form
Vital Signs, Height & Weight:	

System	WNL	Comments and/or Concerns
HEENT		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Respiratory		*(if student has asthma, please include asthma action plan)*
Musculoskeletal		
Neurological		
Mental Health		

Is there any condition that would prevent this child from working with animals in a barn and/or participating in sports or other physical activities? **No - Unrestricted** _____ **Yes - Restricted:** _____

This child has been screened for risk of TB and tested if necessary _____

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). I have attached any relevant physical examination notes.

Provider Name: _____ **Provider Signature:** _____

Date: _____ **Phone:** _____ **Email:** _____

Address: _____

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2025 IMMUNIZATION RECORD

To be completed by the student's healthcare provider

Student Name:		**Student DOB:**	

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 (MM/DD/YYYY)

REQUIRED IMMUNIZATIONS

IMMUNIZATION	DATE ADMINISTERED (MM/DD/YYYY)		
Tdap Booster Pertussis-containing tetanus booster **within last 10 years required**	**Dose 1:**		
Measles/Mumps/Rubella Combination (MMR) 2 dose series OR lab evidence of immunity	**Dose 1:**	**Dose 2:**	**Lab evidence of immunity for all components:**
Varicella (Chicken Pox) 2 dose series OR documentation of history of disease OR lab evidence of immunity	**Dose 1:**	**Dose 2:**	**Evidence of immunity:** History of disease at age_____years
Meningococcal (MCV4, MCV7) 2 dose series with first dose aged 11-12 years and booster after age 16	**Dose 1:**	**Dose 2:**	
COVID-19 2 dose series plus booster dose	**Dose 1:**	**Dose 2:**	**Booster date:** **History of illness:**

OTHER IMMUNIZATIONS (current influenza, etc)

IMMUNIZATION	DATE ADMINISTERED (MM/DD/YYYY)				

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

Provider Name: _____ **Provider Signature:** _____

Date: _____ **Phone:** _____ **Email:** _____

Address: _____

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2025 PRESCRIPTION MEDICATION ORDER FORM

To be completed by the student's healthcare provider

Student Name:		**Student DOB:**	

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. **If possible, please consider ordering a supply of medication(s) for the program length of stay in pre-packed Pill Blister Packs through your pharmacy.** 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.

Epi-pen: ❑ Yes ❑ No **Inhaler:** ❑ Yes ❑ No ❑ **No Known Drug Allergies**

❑ **Allergies:**_____

Health Services Standard Medication Administration Times

- **Morning (7:45am-10am)** (no morning stimulants after 10am unless specified by prescriber)
- **Afternoon (12pm-4pm)**
- **Bedtime (9pm-10pm)** (from Summer Programs Office)

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

Provider Name: _____ **Provider Signature:** _____

Date: _____ **Phone:** _____ **Email:** _____

Address: _____

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2025 MENTAL HEALTH PROVIDER REPORT

To be completed by the student's mental health provider

Student Name:		**Student DOB:**	

Dear 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. We encourage students who are in regular therapeutic counseling to schedule a telephone check-in once or twice during the program. If it is your opinion that this student needs more support, please note that we may not be able to accommodate their needs 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?
Has the student engaged in any self harm, suicidal ideation, or attempts in the past 12 months?
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. If so: ❑Email or ❑Phone

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

Provider Name: _____ **Provider Signature:** _____

License, Title, Degree: _____ **Today's Date:** _____

Phone: _____ **Email:** _____

Address: _____