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

Winter/Spring 2025

Dear Parent/Guardian,

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.

All Parents/Guardians must complete and **return to us** no later than **May 15, 2025**:
- ☐ Emergency Information & Permission to Treat
- ☐ Student Health Insurance Coverage
- ☐ Student Health History

All Parents/Guardians and students must complete and **return to us** no later than **May 15, 2025**:
- ☐ Acknowledgment of our Health Policies
- ☐ Authorization to Administer Medication
- ☐ Concussion Action Plan (read the plan, and sign that it has been read on the Acknowledgment of our Health Policies)

Healthcare Providers must complete and **return to us** no later than **May 15, 2025**:
- ☐ Physical Examination (completed within the last 12 months)
- ☐ Complete Immunization Record (see below if exempt)

If applicable: Healthcare Providers must complete and return to us **no later than May 15, 2025**:
- ☐ Prescription Medications Order Form
- ☐ Mental Health Provider Report
- ☐ Immunization Religious Exemption Form **or** Medical Exemption Form

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

Our team looks forward to being a part of your child's summer at The Putney School Summer Arts. Thank you for providing us the information to make that possible! 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 EMERGENCY INFORMATION & PERMISSION TO TREAT

To be completed by the student's parent / guardian

Student name:		**Date of birth:**	
Preferred name:		**Sex assigned at birth:**	
Gender identity:		**Date of last Tetanus:**	
Primary language:		**Allergies:**	

Pertinent Medical History:	
Current Medications:	
Primary physician contact details:	

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: _____ PRINT NAME: _____

Home Address: _____

Mobile Phone: _____ Email: _____

Alternate Emergency Contact: _____

Person Responsible for Payment: _____

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2025 STUDENT HEALTH INSURANCE COVERAGE

To be completed by the student's parent / guardian

International students who are not covered by a health insurance policy issued in the United States will be enrolled in a policy offered by the school's insurance provider.

Student name:		**Date of birth:**	
Insurance carrier:		**Group / ID number:**	
Subscriber's name:		**Subscriber's date of birth**	
Notes or details of any limitations to coverage (e.g. preauthorization required, no Urgent Care coverage):			

Please include a legible image of the FRONT of the insurance card in the space below:

FRONT OF CARD

Please include a legible image of the BACK of the insurance card in the space below:

BACK OF CARD

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2025 STUDENT HEALTH HISTORY

To be completed by the student's parent / guardian

Student Name:_____**Date of Birth (MM/DD/YY):** _____

Requires Epi-pen? Yes / No | Inhaler? Yes / No | Other emergency medication? _____

It is recommended that students bring at least 2 epi-pens/inhalers/etc. One for the student to have with them, and one to store in Health Services.

Current Medications:_____

_____

If any medications or emergency medicines are listed here, your prescribing physician must ***complete our 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 use/abuse?			
Had inpatient hospitalization for mental health?			
Exhibited suicidal or self-harming tendencies?			

Check all that apply to your child and provide details on reverse side:

❑ ADHD/ADD
❑ Anemia
❑ Anxiety
❑ Asthma (inhaler yes/no)
❑ Dietary Restrictions:_____
❑ Chronic headaches/migraines
❑ Counseling
❑ Depression
❑ Eating/body image disorder
❑ Other:_____
❑ Severe menstrual cramps
❑ Seasonal allergies
❑ Sleep difficulties
❑ Stomach aches/digestive issues
❑ Other: _____

Is there anything else we should know about your child's physical health, wellbeing, mental health, or learning needs in order to help them thrive at The Putney School Summer Arts? Use space on the back of this page, if needed.

_____

_____

_____

_____

_____

Parent/Guardian Signature: _____ **PRINT NAME:** _____

Date Signed: _____

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2025 ACKNOWLEDGMENT OF HEALTH POLICIES

To be completed by the student and their parent / guardian

Student Name:_____ Date of Birth (MM/DD/YY): _____

RESPIRATORY ILLNESS PLANS: At this time, THE CDC has updated guidance for COVID to align with that of other respiratory illnesses. We continue to recommend voluntary masking for all respiratory illnesses and testing for COVID and Flu will be conducted at the discretion of our nursing staff. We will follow the State of Vermont Health Department and US Centers for Disease Control and Prevention (CDC) Guidelines to maintain the health of the community. It is important to note that even with appropriate precautions in place, we may have cases of respiratory illness on campus and we will have plans in place to manage these and mitigate the spread.

ACKNOWLEDGEMENT of RESPIRATORY ILLNESS PLANS: We have received and read the information provided by The Putney School Summer Arts Program. My child and I understand the information provided and agree to abide by any behavioral expectations and inform the health office staff of any signs or symptoms of illness or any known exposures.

Parent/Guardian Initials _____

TICKS and TICKBORNE ILLNESS: Putney is a beautiful place to spend the summer and we strongly encourage our program participants to explore our natural surroundings in the fields and woods of our campus. Unfortunately we share this beautiful place with ticks, some of which carry tickborne illnesses such as Lyme disease and anaplasmosis. It is important to practice tick bite prevention in order to reduce the risk of contracting a tickborne illness. Using a tick repellent and checking your body daily for ticks are important practices to prevent tick bites. If you have been bitten, remove the tick as soon as possible, notify your healthcare provider of the bite, and then monitor yourself for symptoms of tickborne illness to give yourself the best chance of preventing illness and receiving treatment in a timely manner. For more information, please visit the VT Department of Health website.

ACKNOWLEDGEMENT of TICKS and TICK BORNE ILLNESS INFORMATION: We have received and read the Ticks and Tick borne Illness information provided by The Putney School Summer Arts Program. My child and I understand the information provided and agree to inform the health office staff of any tick bites or signs/symptoms of tick borne illness.

Parent/Guardian Initials _____

MENTAL HEALTH SUPPORT: The health and wellbeing of our program participants is our highest priority. We understand that many of our participants may be experiencing mental health challenges. While our health office is staffed by well qualified and licensed nurses, we do not have a mental health provider on staff during the summer program. We can administer prescribed medications, offer nursing assessment and treatment as appropriate, refer to a local emergency room if needed, and assist with remote consultation with a student's home mental health provider if necessary. It is important that we have all the necessary information to support your child while they are here. Please note any mental health concerns on the health history form or contact us if you have specific questions. If a student has been seen by a mental health provider in the last 12 months, we require the provider to complete our mental health report.

ACKNOWLEDGEMENT of MENTAL HEALTH SUPPORT INFORMATION: We have received and read the Mental Health Support information provided by The Putney School Summer Arts Program. My child and I understand the information provided and agree to inform the health office staff of any mental health diagnoses or concerns.

Parent/Guardian Initials _____

ACKNOWLEDGEMENT of CONCUSSION ACTION PLAN: We have received and read the concussion information provided by The Putney School Summer Arts Program. My child and I understand the information provided and agree to notify the Health Services Nurses immediately of any possible head injury during the program and to follow their instructions.

Student Initials _____ Parent/Guardian Initials _____

Please be aware that if your child is experiencing any illness, injury, and/or mental/psychological distress, such that they are not able to participate fully in the summer program, you will be contacted to make arrangements for them to go home for more appropriate care and support.

By initialing above and signing below, you are indicating your understanding and agreement of our health policies.

Student Signature:_____ Date:_____

Parent/guardian Signature:_____ Date: _____

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2025 AUTHORIZATION TO ADMINISTER MEDICATION

To be completed by the student and their parent / guardian

Student Name: _____ **Date of Birth (MM/DD/YY):** _____

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 administered by summer programs staff. 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 program 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 action 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 Summer Arts. Prescription medications from home **must** be accompanied by a Medication Order Form signed by the prescriber. 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 Summer Arts personnel designated by Health Services to administer standard over-the-counter medications (aside from any 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 Summer Arts personnel designated by Health Services.

Parent/guardian initials _____

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

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

Student initials _____

Student Signature: _____ **Date:** _____

Parent/guardian Signature: _____ **Date:** _____