HEALTH AND MEDICAL FORMS CHECKLIST (due July 15, 2013)

Please return forms to Suffield Academy via mail, fax, or email.

Mail: Suffield Academy, Attn: Kim Goodwin, 185 North Main Street, Suffield, CT 06078
Fax: 860-386-4411
Email: **forms@suffieldacademy.org**
Questions? Call Kim at 860-386-4400

- Acknowledgement of Suffield Academy Medical Philosophy
- Physical Examination Record for **New Students**
  or
  Physical Examination Record for **Returning Students**
- Immunization History for **New Students**
- Permission for Medical or Surgical Treatment for All Students
- Permission to Administer Influenza Vaccine
- Suffield Academy Concussion Testing
- Student Health Insurance Waiver/Enrollment
- Copy of Health Insurance Card (front and back)
  if not enrolling in Suffield Academy insurance plan

Additional forms, if applicable:

- Administration of Prescription Medicine by School Personnel Authorization
- Consent to Use Electronic Signatures Program

HEALTH CENTER POLICIES

Most of the routine services of the Health Center are covered by tuition. Our professional nurses evaluate students for common maladies; most over-the-counter medications are provided for students with headaches, colds, minor injuries and illnesses; ace bandages, crutches, ice packs, splints, and other similar supplies are also provided free of charge (with a few exceptions).

Our medical director, Dr. Ross Porter, Board Certified in Pediatrics, comes to campus on Friday mornings and sees students who are ill or who need physicals, allergy injections, etc. The services of Dr. Porter and his associates are not covered by tuition. Please check with your insurance company to verify whether visits to see Dr. Porter will be covered. If a referral is needed from your child's primary doctor to see Dr. Porter or another medical professional, please indicate this on the permission to treat form. The office of the medical professional your child visits will submit claims to your insurance company, but the ultimate responsibility for any bills incurred from medical professionals while your child is at school is yours. If bills remain outstanding for long periods of time, the Suffield Academy Business Office will deduct payment from your child's debit card account.

Prescription medications are obtained from Partner RX Pharmacy in East Windsor, CT; or CVS Pharmacy in Suffield. The pharmacy is given your insurance information and will bill the insurance company directly. Co-payments or full reimbursement for services will be billed to the family directly or deducted from your child's debit account.

The Health Center coordinates transportation, which is provided by hired drivers, for medical appointments scheduled off-campus. The cost for this transportation is $20 per hour and will be deducted from the student's debit card account. There will be a charge of $20 if a student does not show up to meet the driver at the scheduled time, unless the student notifies the Health Center at least two hours in advance.

Flu vaccinations will be provided to students and are recommended. The cost of the vaccination is $25 and may be deducted from the student's debit card account. Once the flu vaccinations have been ordered, payment is required. **Please do not sign this form if you intend on going to your own primary care provider as this fee is non-refundable.**

All narcotic and mood-altering prescription medications are kept in the Health Center and must be supplied in a blister pack from your pharmacy or from one of our local pharmacies. All medication must be in the original container from the pharmacy and labeled. Prescriptions that are self-administered must be accompanied by written instructions as to strength, dose and duration by the student's physician. Prescriptions for controlled substance drugs and psychotropics must be kept at the Health Center and must be accompanied by the physician's statement for administration.

If you have questions regarding our financial or health care policies, please call the Health Center at 860-386-4503.

ACKNOWLEDGEMENT OF SUFFIELD ACADEMY MEDICAL PHILOSOPHY

NAME OF STUDENT

First Name Middle Name Last Name

All Suffield students, both returning and new, must have an annual physical. The completed form must be returned to the Health Center by July 15. **No student will be allowed to participate in school or athletic activities without a current physical. Parents will be notified at least one month in advance when the next physical is due.**

Prescriptions that are self-administered must be accompanied by written directions as to strength, dose, and duration by the student's physician. Prescriptions for controlled substance drugs must be kept at the Health Center. **All prescription medication kept on campus must be checked in through the Health Center.** Medications that are to be kept in the dormitory will be noted in the medical record, and the Health Center will affix a label to the bottle identifying that this is safe to keep in the dorm and is documented. Medication not checked-in is considered contraband, and the matter will be transferred to the Dean of Students' Office. A few medications (controlled and many psychotropics) are required to be kept in the Health Center and dispensed by the Health Center staff. All medications must be brought to the Health Center within 24 hours upon arrival or return to school.

Any required immunizations that are not complete may be administered at the Health Center.

Parent or Guardian Name (please print and sign) Date

☐ **By checking this box and entering the student ID number above, you are signing this document electronically.**

SUFFIELD ACADEMY
Suffield, Connecticut / 860.386.4400

[2013/14 STUDENT FORMS]
ID# **DATE OF BIRTH**

PHYSICAL EXAMINATION RECORD FOR ***NEW*** **STUDENTS**

Please be thorough. Omission of known health problems can jeopardize a student's health care and well-being. A physical examination must be filed **each year** before a student may participate in any part of the school program. **Physical exams must be done within one year from date of last physical; yearly physical exams are required.**

NAME OF STUDENT

First Name _____ Middle Name _____ Last Name _____

Blood pressure _____ Pulse _____

Height _____ inches

Weight _____ pounds

Urinalysis _____

sugar _____

albumin _____

micro _____

Hemoglobin or hematocrit _____

Asthma (preventative & emergency treatment) _____

_____

Allergies (please list) _____

_____

_____

Does student use Epipen? ☐ Yes ☐ No

Prior medical/psychological conditions: _____

Previous musculoskeletal injuries: _____

Current medical/psychological conditions: _____

Psychotherapy or counseling history: _____

REVIEW OF SYSTEMS Describe fully. Use additional sheet if needed.

	WNL	ABNL
Head, ears, nose, throat		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
Any other conditions		

MEDICATIONS TO BE CONTINUED AT SCHOOL
(please list dose and schedule for each medication)

_____

_____

_____

_____

_____

My examination finds the student named above to be in good health, free from contagion, and physically and emotionally qualified for a full program of study and sports.

☐ Yes ☐ No If no, please explain: _____

_____

PRINT OR TYPE NAME AND ADDRESS OF EXAMINING PHYSICIAN

Name _____ Phone Number _____

Street _____ City _____ State _____ Country _____ Zip Code _____

Physician's Signature (required) _____ Date _____

[FORM DUE: 07.15.13]

SUFFIELD ACADEMY
Suffield, Connecticut / 860.386.4400

2013/14 STUDENT FORMS
ID# **DATE OF BIRTH**

IMMUNIZATION HISTORY FOR ***NEW*** **STUDENTS**

CONNECTICUT STATE LAW REQUIRES THE FOLLOWING:

DTaP/Td/Tdap at least 4 doses. Last dose must be given on/ after the 4th birthday. Students who start series at age 7 or older only need a total of 3 doses.

Polio at least 3 doses. The last dose must be given on or after the 4th birthday.

MMR 2 doses separated by at least 28 days, 1st dose on or after the 1st birthday.

Hepatitis B 3 doses, last dose on/after 24 weeks of age.

A Varicella (chickenpox) 1 dose on or after the 1st birthday or verification of disease.

Meningitis 1 dose

NAME OF STUDENT

First Name Middle Name Last Name

IMMUNIZATION HISTORY (PLEASE LIST ALL DATES; BOXES WITH AN * MUST INCLUDE A MONTH/DAY/YEAR DATE)

	1	2	3	4	5	6
DTaP/Td/Tdap	*	*	*	*		
TOPV/IPV (three doses; one dose after age 4)	*	*	*			
M.M.R	*	*				
or 1. German Measles (Rubella)	*					
2. Measles	*	*				
3. Mumps	*					
Hepatitis B	*	*	*			
HIB						
Varicella (chickenpox) (immunization or date of disease)	*	*				
Meningitis	*					
Hepatitis A						
Gardisil (HPV)						
Influenza						

TUBERCULIN SKIN TEST (**required** for new students within the past year)

Date _____ Type _____ Results ☐ negative ☐ positive (if result is positive; chest x-ray required)

Physician's Signature (required) Date

[FORM DUE: 07.15.13]

PERMISSION FOR MEDICAL OR SURGICAL TREATMENT

TREATMENT WAIVER: This form must be signed by the student's parent or legal guardian so that appropriate diagnosis and treatment may be promptly administered and so that no unnecessary delays will occur in case of a medical or surgical emergency. In the event of an emergency, every attempt will be made to contact and fully inform the parents or legal guardian. I hereby authorize the physician (M.D.) of Suffield Academy, Suffield, Connecticut, to procure and administer any care, medical or surgical, and any hospital care deemed necessary to restore health to my son or daughter. My son or daughter has my permission to self-administer any medication, ordered by the school physician or consulting physician, with the approval of the school nurse. The Headmaster or his designee may give permission for surgical or medical treatment for my son or daughter in the event I/we cannot be contacted. I authorize the school nurse or authorized faculty member to administer medications prescribed by the school physician or consulting physician. I further authorize that medical information be released to faculty and advisors on a need to know basis.

NAME OF STUDENT

First Name _____ Middle Name _____ Last Name _____

Student's Social Security Number _____ Check one: Male ☐ Female ☐ Does student use Epipen? ☐ Yes ☐ o

List Any Known Allergies _____

Parent or Guardian Name (please print and sign) _____ Date _____

PARENT OR GUARDIAN CONTACT INFORMATION

Name _____ Relationship to Student _____

Street _____ City _____ State _____ Country _____ Zip Code _____

Home Phone _____ Cell Phone _____ Business Phone _____ Email _____

IN CASE THE PARENT OR GUARDIAN LISTED ABOVE CANNOT BE REACHED, PLEASE CONTACT

Name _____ Relationship to Student _____

Street _____ City _____ State _____ Country _____ Zip Code _____

Home Phone _____ Cell Phone _____ Business Phone _____ Email _____

MEDICAL INSURANCE INFORMATION

Is a referral needed _____ PCP Name _____ Phone _____ Fax _____

Name of Insurance _____ Insurance Company's Phone Number _____

Address to mail claim form _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Subscriber's Place of Employment _____

Insurance Identification Number _____ Subscriber's Social Security number _____

PLEASE PROVIDE AN ENLARGED COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS.

IMPORTANT INFORMATION ABOUT INFLUENZA AND INFLUENZA VACCINE

WHAT IS INFLUENZA ("FLU")?
Influenza (or "flu") is a viral infection of the nose, throat, bronchial tubes and lungs that can make someone of any age ill. Usually the flu occurs in the United States from about November to April. If you get the flu, you usually have fever, chills, cough and soreness and aching in your back, arms and legs. Although most people are ill for only a few days, some persons have a much more serious illness and may need to go to the hospital. On average, thousands of people die each year in the United States from the flu or related complications.

WHO SHOULD GET INFLUENZA VACCINE?
Because influenza is usually not life threatening in healthy individuals and most people recover fully, health officials emphasize the use of vaccine for persons who are at increased risk of complications from this illness. Persons who are at an increased risk of complications who should receive the influenza vaccine include:

- children and adults with severe asthma, heart disease, diabetes, cystic fibrosis, kidney disease or anemia which has required regular visits to the doctor or hospitalization
- children and adults who have a type of cancer or immunological disorder that lowers the body's normal resistance to infections
- children and teenagers on long-term treatment with aspirin who, if they catch the flu, may be at risk of getting Reye's syndrome (a childhood disease that causes coma, liver damage and death)
- residents of institutions housing patients of any age who have serious long-term health problems

In addition, any person wishing to reduce their chances of getting the flu may choose to receive a flu shot, including:

- students or other persons in schools and colleges, if a flu outbreak would cause major disruptions of school activities
- persons traveling to the tropics at any time of the year or to countries to the south of the equator during April–September

INFLUENZA VACCINE
Only a single flu shot is needed each season for persons 9 years of age and older, but children 8 years of age or younger may need a second shot after a month. Children less than 13 years old should be given only vaccine that has been chemically treated during manufacture (split virus) to reduce the chances of any side effects. Split-virus vaccines can also be used by adults.

POSSIBLE SIDE EFFECTS FROM THE VACCINE
Most people have no side effects from recent influenza vaccines. Flu shots are given by injection, usually into a muscle of the upper arm. This may cause soreness for a day or two at the injection site and occasionally may also cause a fever or achiness for one or two days. Unlike the 1976 swine flu vaccine, recent flu shots have not been clearly linked to the paralytic illness Guillain-Barr syndrome (GBS). In 1990-91 there may have been a small increase in GBS cases in vaccinated persons 18 to 64 years of age, but not in those under 18 or those over 65. This possible association with GBS was not as convincing as with the swine flu vaccine. Even if GBS was a true side effect, the very low estimated risk of getting GBS is less than that of getting severe influenza that would be prevented by the vaccine. As is the case with most drugs or vaccines, there is a possibility that allergic or more serious reaction, or even death, could occur with the flu shot.

PEOPLE WHO SHOULD CHECK WITH A DOCTOR BEFORE TAKING INFLUENZA VACCINE

- Persons with an allergy to eggs that causes a dangerous reaction if they eat eggs and those who have had a serious reaction to previous influenza vaccination should consult a physician before receiving the vaccine.
- Anyone who has ever been paralyzed with Guillain-Barr syndrome should seek advice from their doctor about special risks that might exist in their cases.
- Women who are or might be pregnant should consult with their doctor.
- Persons who are ill and have a fever should ask their doctor whether or not they should delay vaccination until the fever and other temporary symptoms have gone.

QUESTIONS
If you have any questions about influenza or influenza vaccination, please call us at the Health Center at 860-386-4503 or call your child's doctor before signing this form.

PERMISSION TO ADMINISTER INFLUENZA VACCINE

PLEASE SIGN AND RETURN THIS FORM, INDICATING YOUR INSTRUCTIONS. THE COST OF THE VACCINE IS $25.

I have read the information sheet and I hereby authorize the Health Center staff to administer the influenza vaccine to:

NAME OF STUDENT

First Name Middle Name Last Name

I authorize a $25 charge to my child's debit card account. **This charge is non-refundable if you sign this form as we order from this request. Please do not sign this form if you intend on going to your own primary care provider.**

Parent or Guardian Name (please print and sign) Date

☐ **By checking this box and entering the student ID number above, you are signing this document electronically.**

SUFFIELD ACADEMY CONCUSSION TESTING

Every student at Suffield Academy is required to participate in our ImPact Concussion testing program. The ImPACT test provides computerized neurocognitive assessment tools and services that are used by medical doctors, psychologists, athletic trainers, and other licensed healthcare professionals to assist them in determining an athlete's ability to return to play after suffering a concussion.

The test works by first taking a Baseline test to collect individual scores for each student. If a student were to get a head injury and exhibit concussive symptoms, they take the test again and their scores are compared to their baseline. Along with these scores and their current symptoms an evaluation and plan are made to help the student rest and heal accordingly. When the student is symptom free and has good ImPact scores compared to baseline, they begin our supervised return to play protocol. The return to play protocol consists of biking, jogging, non-contact, and contact sports, eventually clearing them to return to play their sport.

We require that new students take their baseline tests at home before they come to school. Students will not be allowed to begin their athletic season until they have taken a baseline test.

- **Tests should be taken in a quiet room, away from distractions, with the computer plugged in to a power source.**
- **Tests are taken using the Safari internet browser**
- **An External Mouse must be used**

IMPACT TEST INSTRUCTIONS

1. Open broswer.
2. Uncheck "Block Pop-Up Windows" in your browser.
3. In the browser type in "https://www.impacttestonline.com/colleges" and hit the return button.
4. In the pull down menu for "Please Select Your Organization" select Connecticut then hit the "Launch Baseline Test" button.
5. When prompted, enter the following code: 58415F7283. After entering the code hit the "Launch Baseline Test" button.
6. Read all instructions carefully.
7. You will be asked what country you are from. If your country is not listed, pick the closest country geographically.
8. When asked "what position you play" you can leave it blank unless you are a goalie in a sport you play. If that is the case, type in goalie.
9. Read all the directions very carefully and take your time.
10. The test will take approximately 30-35 minutes.

The school will be notified upon your completion.

MEDICAL INSURANCE WAIVER/ENROLLMENT FORM FOR SUFFIELD ACADEMY STUDENTS

Suffield Academy requires that all enrolled students have insurance to cover emergency and other medical services that may be needed while they are at school. Suffield Academy offers an insurance package through the Student Insurance Division of the Mega Insurance Companies. This coverage is used by many independent schools, as well as colleges and universities. This Suffield Academy Insurance Plan is designed for students who do not have existing coverage. A brief description of the coverage follows this form. Your child will receive an identification card and full description of benefits if you enroll in the program for the 2013-2014 school year. Our Health Center coordinates the interaction between health care providers and the insurance company.

The premium cost for the plan offered is **$1,895** and it covers the ten-month period from August 15, 2013 through June 15, 2014.

If you have any questions, you may call the Business Office at 860-386-4400, or email pdellabernarda@suffieldacademy.org.

If you already have medical insurance coverage that will cover your child's expenses while at Suffield Academy, and you have provided written documentation of that coverage (attach a copy of your insurance card to the Permission for Medical or Surgical Treatment form, or scan and email your insurance card), please check Box A, sign, and return this Waiver/Enrollment form. **If you cannot provide such documentation, you will be required to purchase the Suffield Academy Insurance Plan coverage.** In order to enroll your child in the insurance program at Suffield, please check Box B on this Waiver/Enrollment form, sign the form and return it with your check (in U.S. dollars).

STUDENT HEALTH INSURANCE WAIVER/ENROLLMENT

NAME OF STUDENT

First Name Middle Name Last Name

PLEASE CHOOSE EITHER OPTION A (WAIVER) OR B (ENROLLMENT) AND SIGN THE FORM BELOW

☐ **A: WAIVER (If you have existing medical insurance coverage)**
As parent (guardian), I certify that the student listed above has medical insurance which will cover expenses incurred by illness or injury while attending Suffield Academy. I have provided a copy of the front and back of the insurance card, which will be on file in the Suffield Academy Health Center. I decline enrollment in the Suffield Academy Insurance Plan.

☐ **B: ENROLLMENT**
If you do not have existing medical insurance for your child, you must enroll in Suffield Academy Insurance Plan. Premium cost is **$1,895** (for coverage through June 15, 2014). Please enroll the above named student in the medical insurance program offered through Suffield Academy. I have enclosed payment in U.S. Dollars for the premium cost of the Suffield Academy Insurance Plan; I understand that the coverage will begin August 15, 2013, or when I pay the premium, whichever date is later. Please print this form and send it with payment to **Suffield Academy, Attn. Paula Della Bernarda, 185 North Main Street, Suffield, CT 06078.**

Parent or Guardian Name (please print and sign) Date

☐ **By checking this box and entering the student ID number above, you are signing this document electronically.**

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICINE BY SCHOOL PERSONNEL

Any medication prescribed for a student must be reported to the Health Center. This form must be completed for all controlled substances, mood altering medications, and any other medication to be dispensed by school personnel. Connecticut State statute requires a physician's or dentist's written order and the parent's/guardian's authorization for a nurse to administer prescription medicine.

Medications must be in pharmacy-prepared blister-pack containers and labeled with the student's name, name of the drug, strength, dose, frequency, physician's or dentist's name, and date of the original prescription. The physician's name and order must be the same on the authorization form and prescription bottle. **All prescriptions may be included on this form.** Photocopies of this form are acceptable.

PHYSICIAN'S ORDER _____

NAME OF STUDENT

_____
First Name Middle Name Last Name

Diagnosis: _____

_____

I have evaluated and examined the student on (date) _____ and plan to reassess the medication and treatment plan on (date) _____

Drug: (name, dose, frequency and method of administration) _____

_____

_____

Medication shall be administered from: (date) _____ to: (date) _____

Relevant side effects to be observed, if any: _____

_____

If there are side effects, give plan for management: _____

_____

Is this a controlled drug? ☐ Yes ☐ No If yes, DEA # _____

PRINT OR TYPE NAME AND ADDRESS OF EXAMINING PHYSICIAN

_____ _____ _____
Name Phone Fax

_____
Street City State Country Zip Code

_____ _____
Physician's Signature (required) Date

[FORM DUE: 07.15.13]

CONSENT TO USE ELECTRONIC SIGNATURES PROGRAM

TO THE PARENT(S) OR LEGAL GUARDIANS OF STUDENTS AT SUFFIELD ACADEMY, CLASSES OF 2014, 2015, 2016 AND 2017:

As of June 1, 2012, Suffield Academy ("Suffield") began implementing an Electronic Signature Program. Under this system, parents and legal guardians of Suffield students sign certain forms by completeing them electronically during the course of their child's time at Suffield Academy. These forms will be electronically retained by Suffield.

Participation in the Electronic Signature Program is optional.

To participate in the Electronic Signature Program, please read the following information carefully. If you have any questions regarding the Electronic Signature Program, please contact Patrick Booth, Chief Financial Officer at pbooth@suffieldacademy.org.

ELECTRONIC SIGNATURE PROGRAM: PARENT INFORMATION

Participation is optional. Suffield's Electronic Signature Program is designed to be an optional convenience for parents. You are not required to participate. A decision not to participate does not affect your rights regarding disclosure of school records or your access to those records. You can simply print out the attached forms and send them back to Suffield Academy, 185 North Main Street, Suffield, Connecticut 06078. However, we strongly urge you to consider the benefits of an electronic signature, including better data accuracy, and a more green approach to paper management.

You may withdraw your consent at any time. If you choose to participate in the Electronic Signature Program now, but change your mind later, you may withdraw your consent. Doing so will not result in the assessment of any fees. Please bear in mind that withdrawing your consent will not invalidate any documents you have previously signed electronically.

To withdraw your consent, you may print out and sign a "Withdrawal of Consent to Use of Electronic Signature" form, which is located in the Parent Portal of the Suffield Academy website on the Forms & Documents page (login required). Return the form to the Suffield Academy Business Office via mail or fax.

You may obtain a paper copy of any document you sign electronically. If at any time you wish to receive a paper copy of any document that you have signed electronically, please call or email **Kim Goodwin 860-386-4400** or **kgoodwin@suffieldacademy.org** with your request.

Your consent applies only to certain documents. Your consent to participate in the Electronic Signature Program applies only to online forms (e.g. emergency medical treatment, field trip approval, re-enrollment contracts, plus others as they become necessary.)

You must inform Suffield Academy of any changes in your email address. To effectively participate in the Electronic Signature Program, you must agree to inform Suffield Academy promptly of any changes in your email address.

Consent to Electronic Signatures and Documents: By completing and emailing this consent form to **Kim Goodwin, kgoodwin@suffieldacademy.org** you are providing electronic consent to the use of electronic documents and signatures during your child's Suffield Academy enrollment.

Specifically, you are acknowledging receipt of this form and consenting to the use of electronic documents, email delivery of documents, and electronic signatures in any transactions involving you, your child, and their academic experience at Suffield Academy, including boarding and all extracurricular activities.

☐ **BY CHECKING THIS BOX YOU AGREE THAT THE ADDITION OF YOUR CHILD'S STUDENT ID IN THE TOP RIGHT HAND CORNER OF ALL FORMS ACTS AS AN ELECTRONIC SIGNATURE ON ALL SUFFIELD ACADEMY FORMS.**

NAME OF STUDENT

First Name Middle Name Last Name

NAME OF PARENT/S COMPLETING THIS FORM

First Name Middle Name Last Name

Parent or Guardian Name (please print and sign here) Date