Health Center
271 Pine Nook Road, P.O. Box 7
Deerfield, MA 01372

Dear Parents of New Students,

Included in this online packet are all forms you and / or your doctor will need to complete in order for your child to attend Eaglebrook School. Please take the time to read them all thoroughly. Please address these forms carefully and completely, as we will be better equipped to care for your child upon their arrival.

* Following these steps will make the process much easier.
* **Your child must have a physical exam within the last year. Schedule an appointment now to avoid a delay this summer.**

Return the following forms by August 1st

- **Student Health Data Sheet (1 page)**
- **New Student Medical History (1 page), Healthcare Provider Report (1 page) Immunizations record (1 page)**
- **Permission and acknowledgment (1 page)**
- **Insurance agreement and information (2 pages to complete and 1-2 pages with insurance card copies)**
- **1st year students must complete a baseline Impact test**
- **All medication information and agreement forms need to be returned (1 or 2 pages depending if your child takes certain medications)**

Eaglebrook School Health Center
271 Pine Nook Road, P.O. Box 7
Deerfield, MA 01342
Or
You can scan and email
Or
Fax to 413-774-9297

All forms will need to be completed and returned legibly or we will be unable to accept them and you will need to resubmit them. **No** student is allowed to participate in sports or other activities until all health forms are completed and returned.

FLU VACCINE

Flu vaccination for all EBS students including day students will begin in September. Please be sure to notify us if your child is unable to receive a flu vaccine or has already received one.

If you have any questions, please do not hesitate to contact me
Sincerely,

Brenda M. Wozniakewicz

Brenda M. Wozniakewicz, L.P.N., Health Center Director
Phone: 413-774-9181
Fax: 413-774-9297

Grade: __________

2014 – 2015 Student Health Data Sheet

Student's Name ______________________________________ Birth Date ___/___/___
last first middle

Home Address ______________________________________
street or P.O. box city state ZIP code

Student Resides With: ☐ Both Parents ☐ Father ☐ Mother ☐ Other ____________
please specify

Parent #1 ______________________________
Last first middle

Address: ______________________________

Home Phone: ______________________________

Business Phone: ______________________________

Cell Phone: ______________________________

Email Address: ______________________________

Fax Number: ______________________________

Occupation: ______________________ Age: ______

Parent #2 ______________________________
Last first middle

Address: ______________________________

Home Phone: ______________________________

Business Phone: ______________________________

Cell Phone: ______________________________

Email Address: ______________________________

Fax Number: ______________________________

Occupation: ______________________ Age: ______

If status is other than 'Married', please check all that apply to status of parents: ☐ *separated* ☐ *divorced*
☐ *both parents have custody* ☐ *only parent #1 has custody* ☐ *only parent #2 has custody* ☐ *widow* ☐ *widower*

Emergency Contact - please list someone *other than a parent* who could be contacted in case of an emergency if parent or guardian is not available:

Name: ______________________________ **Home Phone:** ______________

Address: ______________________________ **Business Phone:** ______________

Emergency Medical Information

Please use this space to provide a brief summary of information needed in case of emergency medical treatment while your child is away from school. (More detailed information is requested later).

Medical problems	**Allergies**	**Medications**

Phone: 413-774-9181 | Eaglebrook School | Fax: 413-774-9297

New Student Medical History

Name ______________________________ **Sex** _____ **DOB** ________

Parents: **Please complete this page carefully and thoroughly and return by August 1st.**

Family Medical History

	Age	State of health	Occupation	If deceased, age, date & cause of death
Father				
Mother				
Brothers				
Sisters				

Have any of your relatives had any of the following?	Yes	No	Relationship
Alzheimer's disease			
Arthritis			
Asthma/hay fever			
ADHD			
Bleeding disorder			
Colitis			
Depression			
Diabetes			
Elevated cholesterol			
Epilepsy or seizures			
Heart disease			
High blood pressure			
Kidney disease			
Migraine			
Tuberculosis			

Personal Medical History

Has your child ever had any of the following:		Y	N
Head and throat	Eye problems		
	Frequent ear infections		
	Hearing problem		
	Sinusitis		
	Throat problems		
Cardio-respiratory	Asthma		
	Pneumonia		
	Heart problems		
	High blood pressure		
Gastro-intestinal	Appendicitis		
	Colitis		
	Hernia		
Kidney	Urinary tract infections		
	Kidney/bladder surgery		
	Bedwetting		
other			

		Y	N
Musculoskeletal	Back (including		
	Shoulder		
	Hip		
	Knee		
	Ankle		
	Other		
Neurological/ psychological	Headache		
	Seizures		
	Dizziness or		
	Insomnia		
	Head injury or		
	Anxiety/panic		
	Obsessive/compulsive		
	Depression		
	Attention Deficit		
	Eating disorder (anorexia or bulimia)		

		Y	N
Infectious disease	Measles		
	German measles		
	Mumps		
	Whooping cough		
	Chicken pox		
	Tuberculosis/BCG administration		
	Meningitis/encephalitis		
	Hepatitis		
Miscellaneous	Allergy (specify severity of reaction)		
	drug		
	food		
	other		
	Cancer		
	Diabetes		
	Surgery other than described above		
	Thyroid problem		

Please elaborate on any positive answers or medical problems not noted above:

Has your child ever received treatment or counseling for an emotional or psychological problem other than as already noted?

Please indicate any dietary needs or preferences:

Food allergy:	□Yes	□No
Vegetarian diet:	□Yes	□No
Vegan diet:	□Yes	□No
Other:	□Yes	□No

____
Signature of parent completing this form

____
Date

Eaglebrook School

Healthcare Provider Report

New Student

ph: 413-774-9181
Fax: 413-7749297

Name____Date of Birth______________

Physical Statistics

Height______________Weight________________
Blood Pressure____________Heart Rate__________
Vision
Uncorrected: Right 20/________ Left 20/________
Corrected: Right 20/________ Left 20/________

Laboratory Data

Urinalysis: sugar__________ Protein_____________
Blood:
Specific gravity________________________
Hemoglobin/hematocrit____________________
Cholesterol (optional) ___________________

Physical Examination:

	Normal	Abnormal (explain)
Skin		
Neck		
Lungs		
Genitalia		

	Normal	Abnormal (explain)
HEENT		
Heart		
Abdomen		

Musculoskeletal:

Back:____________________Upper extremities______________________Lower extremities________________

TB Risk Assessment and Testing

1. Does this student have a history of close contact with a person with active TB **yes** or **no**
2. Was this student born in a country with a high prevalence of TB?
   [Africa, Middle East, Asia, Central/South America, Caribbean, Mexico, Eastern Europe] **yes** or **no**
3. Has this student lived or had extensive travel within the past 5 years in a high prevalence country? **yes** or **no**

If the answer to any of the above question is **"yes"** the student is required to have an intradermal TD skin test (PPD) within the last year. If all the answers are **"no"** provide any TB test results that are available but a new TB test is not required. If a TB skin test is positive, please provide a chest x-ray report and details of any drug treatment below

TB test ____________________ **Chest x-ray** ________________**Treatment**______________________

1. Does this student have any chronic medical conditions (e.g., asthma, acne, diabetes migraine)? **No** or **Yes-** (Please explain)

2. Does this student have a history of Attention Deficit Disorder, eating disorder, depression, obsessive-compulsive disorder, bipolar disorder or substance abuse? **No** or **Yes-** (please explain)

3. Is this student capable of a competitive athletic program? **Yes** or **No-** (please explain)

4. **ALLERGIES**? Life Threatening **yes** or **no** Describe reaction e.g., rash, throat closing
   Has he or Does he use an Epi-pen **yes** or **no**

5. **All medications Taken regularly or intermittently (use another page if you need more room)**
   1.____________________________________ 3.____
   2.____________________________________ 4.____

Signature or Healthcare Provider____Date_____________

Print Name____Phone_________________________

Address____

____

Immunization Record

student name______________________________DOB_____

Month/Day/Year are required by law

Immunization	Dose #	Date	Vaccine type	Immuniation	Dose #	Date	vaccine type
				optional Immunizations			
Diptheria,Tetnus,	**1**			HPV	1		
Pertussis	**2**				2		
DTap	**3**				3		
DT, Td	**4**			Hepatitis A	1		
Dtap	5				2		
Tdap	**6**			Typhoid	1		
	7			(oral or Injection)	2		
Polio	**1**			**OTHER**			
(e.g., OPV, IPV)	**2**						
	3						
	4			Serologic Proof	of Immunity	check	one
MMR	**1**			test (if done)	date of test	positive	negative
1st dose after 12 months	**2**			measles	/ /		
Hepatitis B	**1**			mumps	/ /		
	2			Rubella	/ /		
	3			Varicella	/ /		
Varicella	**1**			Hepatitis B	/ /		
1st dose after 12 months	**2**			**Chicken Pox History** Check the box if this person has a physician certified reliable history of chicken pox ☐			
Meningococcal	**1**						
	2						

SIGNATURE OF
HEALTH CARE PROVIDER____Date_______________

Print Name____Phone________________________

Address____

For more information regarding the manditory immunizaions you may go online to:
http://www.mass.gov/eohhs/docs/dph/cdc/immunization/guidelines-ma-school-requirements.pdf.

Immunization Record

student name______________________________DOB_____

PHONE:413-774-9181 FAX: 413-774-9181

Permissions and Acknowledgements

Student's name____Date of Birth___________________

The following permissions and acknowledgements are requested. The signature of a parent or guardian is required on this form prior to participation in classes and sporting activities. Every effort will be made to contact parents or guardian for serious illnesses, serious injuries, operations or protracted or complex treatments.

I hereby grant permission to the school medical staff to provide medical care to my child during the years that he or she attends the above-mentioned school, as well as to submit claims to my insurance carrier for the care provided.

I hereby grant permission to the school medical staff to administer influenza vaccine and any vaccine or immunization required by Massachusetts law or school policy.

I hereby grant permission to the school Medical Director to represent me during the years that my child attends school with full power to authorize and consent to any medical treatment of my child in the event of a medical or surgical emergency, including hospitalization, anesthesia and surgery. This permission is in the event that I am unable to be contacted and medical or surgical judgment indicates that further delay would represent a risk to my child.

I hereby grant permission to the school Medical Director to represent me during the years that my child attends the school with full power to authorize and consent to any treatment for my child in an Emergency Room or medical office and to any imaging exams, including but not limited to X-rays, MRIs and CT scans.

I hereby acknowledge that I have received a Notice of Privacy Practices that describes how the Health Services of the above-mentioned school may use and disclose my child's health information. As noted in the Notice of Privacy Practices, medical information may be shared with the Head of School and her advisors to facilitate decisions concerning a Medical Leave pursuant to the Medical Leave Policy.

I hereby acknowledge that the above-mentioned school does not necessarily conduct or require the health examinations that my state may require for public school students. I understand I can consult with my health care provider, my local school committee or my local board of health to learn more about these exams and that if I want these exams carried out on my child, it will be my responsibility to make such arrangements.

Signature of parent or guardian____ Date____________

Health Insurance Agreement

Dear Parents,
Eaglebrook School requires all students to be covered by a comprehensive health insurance plan. **International students are required to carry the school's health insurance, Primary Plan**. *If you do not enroll in the school's insurance plan and your insurance does not cover a health expense incurred by your child, or if you do not provide accurate information or copies of all insurance coverage as requested below you will be responsible for paying that bill.*

The following plans are available through Clifford Allen Associates. This is a new plan for the 2014-2015 school year. It offers more comprehensive coverage for our students.

PRIMARY PLAN
Provides benefits for those of you who do not have any insurance or whose coverage is not accepted outside of your geographical area. This plan was designed for schools like Eaglebrook School to meet the mandated requirements of the Massachusetts state law. This plan will cover students anywhere in the world for a 10 month period for **$1,695.00.**

SUPPLEMENTAL PLAN
For families who have acceptable primary insurance we **strongly encourage** you to consider purchasing this supplemental coverage. It can help meet upfront deductibles and co-payments as well as other costs not met by your plan when your child is away from home. Your child will be covered while in the USA for a 10 month period for **$455.00.**

You must select one and only one of the three options below. Promptly complete and return to Eaglebrook School Health Center

1. [ ] Enroll____in the Primary plan.
Student name
10 months coverage 9/1/14-6/30/15 for $1,695.00

2. [ ] Enroll____in the Supplemental plan.
Student name
10 months coverage 9/1/14-6/30/15 for $445.00

3. [ ] Do not enroll ____________________________________in either plan
Student name

By choosing Option #3, I accept full responsibility for all medical costs incurred by my child. My present in-force plan is as follows:

Parent/Guardian signature________________________________**Date**______________

2014-2015 Student Insurance Information Eaglebrook School

You must complete this Insurance information form completely and correctly

Student's name____Date of birth______/______/______
Month day year

HEALTH INSURANCE INFORMATION

Name of Insurance Company____

Plan Type______________________________ Policy Holder Name___________________________

Policy Number___________________________ Policy Holder Relationship______________________

Group Number___________________________ Policy Holder DOB____________________________

Policy Holder Employer____

Claims Address____
Address City State ZIP

____
Provider's phone number Member's Service Number

Do you Have prescription coverage? no_______ yes_____ ***BIN number**__________________________

Rx Company___________________Rx Group number________________Rx PCN number_____________

DENTAL INSURANCE INFORMATION

Does your child have dental Insurance? No______yes_____

Insurance company name____phone_______________

____
Address City State Zip

Policy ____
Number ID Cert. Number Group #

Policy Holder's Name____DOB___________________

Employed by____Effective date_________________

You need to include a copy of the front and back of
Enlarged please

1. Health Insurance Card
2. Prescription Card
3. Dental Insurance Card

.

rev. 4/14

Impact Test
Required

Dear Eaglebrook School Student,

We require all new incoming students to complete the Impact concussion baseline test online. This needs to be completed before participating in sports this Fall either competitively or non-competitively.

Then Impact concussion baseline test is a test that we use along with other information to help us determine when you have recovered from a concussion. The baseline test provides us with data that we compare to the test you take later should you sustain a concussion while attending Eaglebrook School.

Test Guidelines:

- It takes approximately 30 minutes to complete the test
- Your computer must have a mouse
- Plug your computer in, do not run on batteries
- Take test in quiet undisturbed room
- If test is not completed in 45 minutes it's invalid
- Read all instructions for each category CAREFULLY
- Be sure your Pop Up Blocker is OFF before you start the test

LOGGING ON AND TAKING THE ONLINE IMPACT TEST INSTRUCTIONS

1. Log onto www.impacttestonline.com/schools/
2. Under "**Please select organization**" choose Massachusetts and click Launch baseline.
3. **Customer ID**, enter **DDC97DC869** and click on launch baseline
4. Click on appropriate language
5. Continue answering all questions carefully

When you complete each module continue on to the next, always reading the directions carefully. When you have completed the entire test, the program will let you know and you may then close out of the program.

Thank you,
Mrs. Wozniakewicz,
Health Center Director.

MEDICATIONS

Health Center
Phone 413-774-9181 fax 413-774-9297
Email healthcenter@eaglebrook.org

Dear Parent,

It is important that both you and your child read and understand the information in this letter. There will be some parts that are highlighted or underlined that need to be paid close attention to. These tend to be areas that have been problematic for parents and students to adhere to in the past. At the end of this information page, there is a place for you and your child to sign. You will need to return it to the health center (make yourself a copy to keep on file to refer back to) prior to our health center being able to dispense medication to your son.

1. **No medication will be accepted from home, if you insist on leaving the medication it will be disposed of**. We have a specific way in which our medications are packaged from Louis and Clark, the pharmacy we work with, to assure the safety and accuracy of the medications we dispense.

2. If you want your son to take medication at home on weekends or vacations you must have a supply at home. We do not mail or allow students to carry medications with them.

3. **No Medication, this includes OTC as well as prescribed is to ever be kept in the student's room.** (due to the age of the student population at Eaglebrook School.) **Failure to comply with this could result in disciplinary action.**

4. Eaglebrook School keeps on hand vitamins of different types. DO NOT send vitamins with your child. It becomes a storage issue and in the past has gotten out of control.

5. Students who take medication are expected to come at the times designated by the Health Center. One attempt to locate a student will be made. Parents will be notified if this becomes a continual problem.

6. Psychotropic Medication is addressed on page 3 of this packet.

Any questions should be directed to Health Center Director.

Sincerely,

Brenda M. Wozniakewicz

Brenda Wozniakewicz, L.P.N., Health Center Director

In addition to this information, you and your child must read, understand and sign the Medication agreement that follows. Again keep a copy of this to refer back to.

Medication Agreement

- I agree to follow the rules established by Eaglebrook School regarding all medications which include Over the Counter (OTC), and Prescription medications of various classifications.
- I agree that I will not send medications with my child nor ask for the school to send medications with my child.
- I agree to provide the Health Center with current prescription insurance plan information in order for EBS to order medication through Louis and Clark Pharmacy.

Parent and Student must sign

I, ____

Print Student's Name

read and will comply with the Medication Policy of Eaglebrook School.

Student's signature____Date___/___/___

I, ____,

Print Parent's Name

give permission to the Health Center staff to administer medication as prescribed to my child. Additionally I have read and will comply with the Medication Policy as outlined.

Parent's Signature____Date___/___/___

Eaglebrook School
Health Center
Phone 413-774-9181
Fax 413-774-9297
Email healtcenter@eaglebrook.org

IMPORTANT NOTICE ABOUT PSYCHOTROPIC MEDICATION

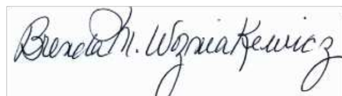
Psychotropic medications are a class of medications used in the treatment of various conditions such as *attention deficit disorder, depression, obsessive-compulsive disorder and panic attacks.*
All of these medications come packaged in a specific way from the pharmacy we work with. We monitor the dispensing of these medications carefully.

If your child is taking any medications in this category please complete the form below. We will then send a medication packet to your child's prescribing physician. It needs to be returned by **August 1**.

Below is a list including but not limited to the psychotropic medications we dispense from the Eaglebrook School Health Center. This list is to assist you with medication knowledge.

Abilify	*Adderall*	*Ambien*	*Ativan*	*Celexa*	*Concerta*
Effexor	*Focalin*	*Lamictal*	*Lexapro*	*Prozac*	*Remeron*
Ritilan	*Strattera*	*Vyvanse*	*Wellbutrin*	*Zoloft*	

Thank you,



Brenda M. Wozniakewicz, L.P.N., Health Center Director

Does your child take psychotropic medication?

___________YES, my child____DOB___/___/____
check here **student's name**

____
Address City State Zip

____
Print Parent's name

____
Parent's signature Date

Physician's name____

Mailing address____

Email address____

Phone number____