CATS ACADEMY BOSTON

CATS Academy Boston

Pre-arrival Contact and Medical Forms

All forms should be completed in their entirety and sent to Student Services at studentservices@catsacademyboston.com

Contact Form

Contact Information

Student name: _____

Student email: _____

Cell phone number (If applicable): _____

Home phone number: _____

Will you be arriving alone or with a companion (family, friend, or other): _____

Name of person(s) traveling with: _____

Contact email of travel companion: _____

Mobile phone number of companion (If applicable): _____

Flight Information

(Please list all flights and airlines you will be taking to Boston, including connecting flights and their times of arrival and departure in case of delays or cancellations)

Airline: _____

Flight number: _____

Date of departure: _____

Time of departure: _____

Date of arrival in Boston: _____

Time of arrival in Boston: _____

Emergency Contact Information

(In case of delays or cancellations with your flight, please provide us with an emergency contact who can be reached to speak on your behalf) _____

Emergency contact name: _____

Relationship to you: _____

Contact email: _____

Contact phone number: _____

Ability to understand and speak English?: _____

Medical Information

CATS Academy Boston requires medical documents before arrival. These forms are required by law and necessary to grant us permission to obtain proper medical treatment for our students. Failure to submit these forms may result in a student's exclusion from CATS Academy Boston. The health and safety of our students is extremely important to us so we expect your complete compliance.

Below you will find descriptions of the individual forms, in parenthesis it says either Parent/Guardian or Health Care Provider which refers to who should be filling out that specific form.

A. Student Medical History Form: (Parent or Guardian)

This form will be kept by the school nurse. The information will help the school nurse to be prepared to help with any minor problems the student might have or the information can be given to a doctor should the student need a doctor's care.

B. Massachusetts Health Record Form: (Health Care Provider)

This document is required by the state of Massachusetts for every student. It must be completed by a doctor, in English. Please note that the doctor must agree that the student has had all immunizations, so it is best to complete all immunizations before completing this form. Also, if the student wishes to participate in P.E. or on a sports team, the doctor must check the appropriate box.

C. Massachusetts Immunization Requirements: (Health Care Provider)

The state of Massachusetts requires that every student be immunized according to specific requirements. An immunization record must be signed by a doctor and submitted before the student's arrival. Form C is our version or the immunization record but we will accept any documentation as long as it is clearly signed by a doctor. It is required that all vaccination series are started, meaning at least one dose, before a student starts school. If the series needs to be completed we will schedule doctors' appointments accordingly.

D. Varicella (Chicken Pox) Verification Form: (Health Care Provider)

Massachusetts law requires that all students be immunized against the Varicella disease. If the student has had chicken pox in the past, they do not have to get the vaccine if this form is signed by a physician, nurse practitioner or physician assistant.

E. Meningococcal Disease Information and Waiver Form: (Parent or Guardian)

Massachusetts law requires that all students living in the dormitory be immunized against the Meningococcal Disease. This document includes information about the risks and dangers of the disease. After reviewing this information the parent can elect to decline the vaccine by signing this waiver form, however we strongly recommend the vaccination.

F. Medication Order and Administration of Medications Form: (Parent or Guardian and Doctor)

The strict U.S. laws regarding student medications require that the student's doctor and parents agree to allow the student to take a specific medication while in the care of the school. Both the doctor and parents must fill out this form. It is highly recommended that all parents complete this form even if their student does not take medication on a regular basis, so that the school can be prepared to help the student if an unexpected problem arises.

G. Administration of Over-the-Counter Medications: (Parent or Guardian)

This form allows the school nurse to administer the medications listed. These medications are to treat common health ailments such as headaches, menstrual cramps, cough, etc. This form is required to be signed by a parent or guardian before any medication is given to a student.

H. Authorization for Medical Treatment: (Parent or Guardian)

Permission from a parent or guardian is required by law in order for our faculty/nurse to obtain medical treatment for any student under the age of 18. This is extremely important so please take the time to fully and accurately complete this form.

I. Authorization for Influenza Vaccine: (Parent or Guardian)

Permission from a parent or guardian is required by law in order for our faculty/nurse to administer the influenza vaccine to any student.

J. Serious Allergy Plan: (Health Care Provider and Parent or Guardian)

Permission to administer EpiPen for students with serious allergies.

Medical Check List

ALL OF THE FOLLOWING MUST BE SUBMITTED BEFORE ARRIVAL TO SCHOOL. Failure to do so will result in exclusion from classes.

Parent/Guardian must fill out:

1. Form A - Health History
2. Form E - Waiver for Meningococcal Vaccination Requirement
3. Form F - Medication Order and Authorization for Administration of Medications - Part 2
4. Form G - Administration of Over-the-Counter Medications
5. Form H - Authorization for Medical Treatment
6. Form I - Authorization for Influenza Vaccine

Doctor / Health Care Provider:

1. Form B - Massachusetts Health Record Form
2. Form C - Massachusetts Immunization Requirements
3. Form D - Varicella (Chicken Pox) Verification Form
4. Form F - Medication Order and Administration of Medications Form - Part 1

Form A - *To be filled out by Parent/Legal Guardian*

Student Health History Information

STUDENT INFORMATION

Name:	Gender:	Nick Name:
Date of Birth:	Age:	Email:
Cell Phone Number:	Grade:	

PARENT/GUARDIAN

Name:	Name:
Phone Number:	Phone Number:
Email:	Email:
Do they speak English? ☐ Yes ☐ No	Do they speak English? ☐ Yes ☐ No

IN CASE OF EMERGENCY WHO SHOULD BE REACHED?

Name:	Name:
Phone Number:	Phone Number:
Email:	Email:
Do they speak English? ☐ Yes ☐ No	Do they speak English? ☐ Yes ☐ No

THE FOLLOWING IS FOR INTERNATIONAL STUDENTS ONLY:

FAMILY IN THE U.S. ☐ YES ☐ NO

Name:	Name:
Phone Number:	Phone Number:
Email:	Email:
Do they speak English? ☐ Yes ☐ No	Do they speak English? ☐ Yes ☐ No
Relation to student:	Relation to student?

DOES THE STUDENT HAVE AN AGENT? ☐ YES ☐ NO

Name:	Name:
Phone Number:	Phone Number:
Email:	Email:

THE FOLLOWING IS FOR HOMESTAY STUDENTS ONLY:

Name of homestay parent(s):	
Phone Number:	Work Number:
Email:	Address:

THE FOLLOWING IS FOR STUDENTS IN A DORMITORY ONLY:

Which dormitory will your child be staying in? ☐ West Roxbury ☐ Boston ☐ Chestnut Hill
Does your child need any emergency medical supplies available in the dorm? ☐ YES ☐ NO *If yes please describe:*

Form A (continued) - *To be filled out by Parent/Legal Guardian*

Please answer the following questions regarding your child named on the previous sheet.

Does your child have any medical conditions or issues, past or present that could potentially be a problem or concern during his or her participation in school? ☐ Yes ☐ No

If YES, please describe: _____

Will your child need ongoing medical treatment for such conditions or issues? ☐ Yes ☐ No

If YES, please describe: _____

ALLERGIES - Please list and describe allergies or reactions to any of the following:

Foods: _____ Medicine or drugs: _____

Plants, animals: _____ Other: _____

Emergency measures if an allergic reaction is severe: _____

Does the student require an EpiPen? ☐ Yes ☐ No

If yes, **Form J - SERIOUS ALLERGY PLAN** must be completed by their doctor and returned prior to the start of the school year.

Does your child have asthma? ☐ Yes ☐ No

If your child uses an inhaler, please describe: _____

Does your child have diabetes? ☐ Yes ☐ No

If YES, please describe the diabetes management plan: _____

Does your child have any dietary restrictions? ☐ Yes ☐ No

If YES, please describe: _____

Is there a history of any hospitalizations, significant injuries or surgery? ☐ Yes ☐ No

If YES, please describe: _____

Is there a history of any mental health issues or learning disabilities? ☐ Yes ☐ No

If YES, please describe: _____

Does your child take any medication? ☐ Yes ☐ No

If YES, please complete Medication Order Form-Form F

Does your child require prescription medication at school? ☐ Yes ☐ No

If YES, please complete Medication Order Form-Form F

Does your child need a doctor here in the U.S. to prescribe medications? ☐ Yes ☐ No

If YES, please list medications below:

1. _____
2. _____
3. _____

Form A (continued) - *To be filled out by Parent/Legal Guardian*

MENTAL HEALTH
Has the student ever been under the care of a mental health professional? ☐ Yes ☐ No

If yes, please describe:

Date		Diagnosis		Treatment

Are your child's immunizations up to date, included in this packet, and signed by a doctor? ☐ Yes ☐ No

Do you give permission to have additional vaccinations completed at school if needed? ☐ Yes ☐ No

Do you give permission for CATS Academy Boston's School Nurses and appropriate staff members delegated by the School Nurses to administer medications? (Both over- the counter and prescription) ☐ Yes ☐ No

If YES, please complete Form F and Form G

Is there any significant medical history in the child's biological family? ☐ Yes ☐ No

☐ Mother ☐Father☐ Siblings ☐ Grandparents

If YES, please describe: _____

Please list any additional concerns or information: _____

_____

_____

Signature of Parent or Guardian #1: _____ Date: _____

Print Name of Parent or Guardian #1: _____

Signature of Parent or Guardian #2: _____ Date: _____

Print Name of Parent or Guardian #2: _____

Signature of Student (If 18 Years of Age or Older): _____ Date: _____

Form B – *To be filled out by Health Care Provider*

MASSACHUSETTS SCHOOL HEALTH RECORD

Name: _____ ☐Male ☐Female Date of Birth:_____ Date of Examination:_____
M/D/Y M/D/Y

Medical History:

Pertinent Family History:

Current Health Issues:

Y N
☐ ☐ Allergies: Please list: Medications: _____ Food: _____ Other: _____

History of Anaphylaxis to _____ Epi-Pen: ☐Yes ☐N o

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (Please attach)
☐ ☐ Diabetes: ☐Type I ☐ Type II
☐ ☐ Seizure disorder:

☐ ☐ *Other* (Please specify)

Current Medications (Prescription ONLY- PLEASE FILL OUT FORM F AS WELL)
1._____ 2. _____ 3. _____ 4. _____

Height: _____ (_____%) Weight: _____ (_____%) BMI: _____ (_____%) BP: _____ P:_____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____ ☐ Skin _____
☐ Heart _____ ☐ Neurologic_____ ☐ Abdomen _____ ☐ Dental/Oral _____
☐ Genitalia _____

Screening:

	(Pass)	(Fail)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

The **Physical Examination** was**:** ☐ Normal ☐ Abnormal If abnormal Please Explain:

Targeted Tuberculosis (TB) Skin Testing

International Students ONLY: Must have yearly screening within six months from the start of the school year.

Mantoux/PPD: REQUIRED FOR INTERNATIONAL STUDENTS (*Note that BBG vaccination does not preclude testing.)*	**Chest X-Ray** (required if greater than or equal to 10mm reaction):
Date: _____Results: _____mm.	Date: _____Results: _____

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other
Comments/Recommendations:

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions**:

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____
Signature of Examiner *Circle*: MD, DO, NP, PA Date *Please print name of Examiner*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student.MDPH 08/15/13

Form C

Immunization and Tuberculosis Screening Requirements for Massachusetts 2014/2015

In order to attend school in Massachusetts, students are required to provide an immunization record signed by a doctor. Before a student can begin classes, all required vaccination series MUST be started. Unfinished vaccination series will be completed as needed as long as parental permission is given.

Immunization Type	Doses
Hepatitis B	3 doses
DTaP/DTP/DT/Td/Tdap	4 DTaP/DTP (Or ≥ 3 td)
Tdap	1 Tdap
Polio	≥ 3 doses
MMR	2 measles 2 mumps 2 rubella (OR 2 MMR)
Varicella	2
Meningococcal *Required for students living in the dormitory	1 dose of MCV4 Or 1 dose or MPSV4 in the past 5 years

VARICELLA – CHICKEN POX

*If a student has had the chickenpox disease and form D is filled out as directed, this vaccine is not required.

MENNINGOCOCCAL – MENINGITIS VACCINE

*Required for ALL students living in the dormitory

TUBERCULOSIS SCREENING - PPD/Mantoux & Chest X-ray if results are Positive (>10 mm)
Required for ALL INTERNATIONAL Students. Documentation signed by a doctor is required before their arrival to school. The results can be recorded on either Form B or Form C

Waiver options:

It is possible to waive the Meningococcal requirement; however it is inadvisable to do so. In order to waive the Meningococcal requirement, you must fill out the Waiver for Meningococcal Vaccination Requirement (Form E). Again, we strongly recommend that you do indeed get the Meningococcal vaccine.

There are two situations in which children who are not appropriately immunized may be admitted to school:

1. a medical exemption is allowed if a physician submits documentation attesting that an immunization is medically contraindicated; and
2. a religious exemption is allowed if a parent or guardian submits a written statement that immunizations conflict with their sincere religious beliefs.

Form C - *To be filled out by Health Care Provider*

Immunization Record

Student's Name: _____ DOB: (M/D/Y) / / Sex: _____

	Date: M/D/Y		Vaccine Type		Date: M/D/Y		Vaccine Type
Hepatitis B	1			**Polio Specification of Vaccine Type Required**	1		
	2				2		
	3			**Types: IPV OR OPV**	3		
	4				4		
	5				5		
Hepatitis B Immunity Test	Date: M/D/Y		Results:		6		
					7		
Diphtheria, Tetanus, Pertussis Specification of Vaccine Type Required Types: DTP, DTaP, DT, Td,	Date: M/D/Y		Vaccine Type	**Meningococcal MCV4 or MPSV4 Required within the last 5 years.**	Date: M/D/Y		Vaccine Type
	1				1		
	2				2		
	3				3		
	4			**BCG Vaccine**	Date: M/D/Y		Vaccine Type
	5				1		
Tdap	Date: M/D/Y		1 Tdap Required		2		
	1			**PPD test REQUIRED FOR INTERNATIONAL STUDENTS**	Date: M/D/Y		Result
MMR	Date: M/D/Y				1		
	1				If >10mm Chest X-ray is Required		
	2			**Varicella**	Date: M/D/Y		Vaccine Type
Measles	Date: M/D/Y				1		
	1				2		
	2			**If Patient had the Varicella disease document date, or proof of Immunity below.**			
Mumps	Date: M/D/Y			**Varicella Disease:**	Approximate Date: M/D/Y		
	1						
	2						
Rubella	Date: M/D/Y			**Varicella Titer test**	Date: M/D/Y		Results:
	1						
	2						

I certify that this immunization information was transferred from the above-named individual's medical records.

Physician, nurse practitioner or physician assistant:

Name: _____ Date: _____ (M/D/Y)

Signature: _____

Facility name: _____

Form D - *To be filled out by Health Care Provider*

Varicella Verification

According to the Massachusetts Department of Public Health, all schools are required to provide a record of two doses of the Varicella Vaccine or a reliable history of the chicken pox disease. A reliable source is as follows:

"In the case of Varicella, upon presentation of laboratory evidence of immunity or a statement signed by a physician, nurse practitioner or physician assistant that the student has a history of chickenpox disease" (CMR 105: 220.500, C-4).

Documentation of prior Varicella illness can be provided by:

1) Attaching a Serologic confirmation or Varicella immunity to this form. (Positive Varicella IgG result)
2) A written statement signed by a physician, nurse practitioner, or a physician assistant (See below)

"This is to verify that _____ (Name of Student) had Varicella disease (chicken pox) on approximately _____ (Month/Day/Year) and does not need the Varicella vaccine."

By signing below, I acknowledge that the above statement is true.

Signature: _____ Date: _____

(Signature of physician, nurse practitioner or physician assistant) (Month/Day/Year)

Form E - *To be filled out by Parent/Legal Guardian*

Waiver for Meningococcal Vaccination Requirement

Information about Meningococcal Disease and Vaccination and Waiver
for Students at Residential Schools and Colleges
[MDPH Meningococcal Information and Waiver Form]

Massachusetts requires all newly enrolled full-time students attending a secondary school (e.g., boarding schools) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to:

1. receive meningococcal vaccine; or
2. fall within one of the exemptions in the law, which are discussed below.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver at the end of this document. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

What is meningococcal disease?
Meningococcal disease is caused by infection with bacteria called Neisseria meningitides. These bacteria can infect the tissue that surrounds the brain and spinal cord called the "meninges" and cause meningitis, or they can infect the blood or other body organs. In the US, about 1,000-3,000 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 11- 19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

How is meningococcal disease spread?
These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person's saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is at most risk for getting meningococcal disease?
High-risk groups include anyone with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited immune disorder), HIV infection, those traveling to countries where meningococcal disease is very common, microbiologists and people who may have been exposed to meningococcal disease during an outbreak. People who live in certain settings such as college freshmen living in dormitories and military recruits are also at greater risk of disease.

Are some students in college and secondary schools at risk for meningococcal disease?
College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving the exchange of saliva), may be what puts college students at a greater risk for infection. There is insufficient information about whether new students in other congregate living situations (*e.g.,* residential schools) may also be at increased risk for meningococcal disease. But, the similarity in their environments and some behaviors may increase their risk.

The risk of meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, meningococcal vaccine is a safe and efficacious way to reduce their risk of contracting this disease.

Is there a vaccine against meningococcal disease?
Yes, there are currently 2 types of vaccines available that protect against 4 of the most common of the 13 serogroups (subgroups) of N. meningitidis that cause serious disease. Meningococcal polysaccharide vaccine is approved for use in those 2 years of age and older. There are 2 licensed meningococcal conjugate vaccines. Menactra® is approved for use in those 9 months — 55

years of age and Menveo® is approved for use in those 2-55 years of age. Both the polysaccharide and conjugate vaccines provide protection against four serogroups of the bacteria, called groups A, C, Y and W-135. These four serogroups account for approximately two-thirds of the cases that occur in the U.S. each year. Most of the remaining one-third of the cases are caused by serogroup B, which is not contained in either vaccine. Meningococcal vaccines are thought to provide protection for approximately 5 years. Currently, students are only required to have a dose of polysaccharide vaccine within the last 5 years or a dose of conjugate vaccine at any time in the past (or fall within one of the exemptions allowed by law).

However, please be aware that in October 2010 the Advisory Committee on Immunization Practices (ACIP) recommended booster doses of meningococcal conjugate vaccine for healthy adolescents 16-18 years of age. Persons up to 21 years of age entering college are recommended to have documentation of a dose of meningococcal conjugate vaccine no more than 5 years before enrollment, particularly if they are new residential students.

Is the meningococcal vaccine safe?

A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women. Anyone who has ever had Guillain-Barre Syndrome should talk with their provider before getting meningococcal conjugate vaccine.

Is it mandatory for students to receive meningococcal vaccine for entry into secondary schools or colleges that provide or license housing?

Massachusetts law (MGL Ch. 76, s.15D) requires newly enrolled full-time students attending a secondary school (those schools with grades 9-12) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to receive meningococcal vaccine. At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. All students covered by the regulations must provide documentation of having received a dose of meningococcal polysaccharide vaccine within the last 5 years (or a dose of meningococcal conjugate vaccine at any time in the past), unless they qualify for one of the exemptions allowed by the law. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; 2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine.

Where can a student get vaccinated?

Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of this vaccine. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?

- Your healthcare provider
- The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph/imm and www.mass.gov/dph/epi
- Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of meningococcal vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools, colleges and universities who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school or postsecondary institution to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Student Name: _____ Date of Birth:_____

Student ID or SSN: _____

Signature of Parent or Guardian #1: _____ Date: _____ Phone: _____

Print Name of Parent or Guardian #1: _____

Signature of Parent/Guardian #2: _____ Date: _____ Phone: _____

Print Name of Parent or Guardian #2: _____

Signature of Student (If 18 Years of Age or Older):_____ Date:_____

Form F - *To be filled out by Health Care Provider*

Medication Order and Authorization for Administration of Medications

Student Name: _____ Date of Birth: _____ Grade: _____

I. Medication Order

To Be Completed By Health Care Provider

Date of Order: _____ Discontinuation Date: _____

Diagnoses (if not in violation of confidentiality): _____

Any other medical condition(s) (if not in violation of confidentiality): _____

Medication Name	Dose	Route	Frequency/Time	☑ applicable boxes below
				☐ RN _____ ☐Bus ☐FT ☐SSA ☐Self-Directed ☐ Self Admin-Self Carry
				☐ RN _____ ☐Bus ☐FT ☐SSA ☐Self-Directed ☐ Self Admin-Self Carry
				☐ RN _____ ☐Bus ☐FT ☐SSA ☐Self-Directed ☐ Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

RN	The School Nurse may administer dose during school hours or train and designate appropriate staff to administer dose during after school hours (Weekends, field trips, sporting events, etc).
Bus	Medication must be available on bus
FT	Medication is needed on field trips
SSA	Medication is needed school sponsored extra-curricular activities
Self-Directed	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.
Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed). Provided that the School Nurse determines it is safe and appropriate, I give this student permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Optional Information

- Special side effects, contraindications, or possible adviser reactions to be observed:
- Other medication being taken by the student:
- The date of the next scheduled visit or when advised to return to Prescriber:

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ **Date** _____

Prescriber's Business Phone _____ **Prescriber's Emergency Phone** _____

Form F - *To be filled out by Parent/Legal Guardian*

Medication Order and Authorization for Administration of Medications

Student Name: _____ Date of Birth: _____ Grade: _____

II. Authorization for Medication Administration

To Be Completed By Parent

Name of Parent/Guardian #1:_____ Home Phone: _____ Work Phone: _____

Name of Parent/Guardian #2:_____ Home Phone: _____ Work Phone: _____

Name of other persons to be notified in case of medication emergency: _____

Relationship:_____ Phone:_____

My child named above is currently receiving the medications listed above\ by the Licensed Prescriber.

By singing below, I give permission for the School Nurse or School personnel designated by the School Nurse to administer the Medication(s) listed on the previous page to my child. I further give permission to the School Nurse to receive and follow prescription or over-the-counter medication orders according to written guidelines and approval of the School Physician as necessary for the health of my child during the school year. I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

I understand I may retrieve the medication from the School at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of the School.

Self-Administer/Self Carry: Parent permission and provider consent is required for students to self-administer and self-carry prescription medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the School Nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. By signing below, I give permission for my child to self-administer and self-carry medication, if the School Nurse determines it is safe and appropriate.

I, the undersigned, do hereby solemnly swear that I have the legal custody of my child. By signing below, I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston and CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releasees"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releasees, which I or my child or our heirs, legal representatives, successors, conservators and assigns may have, now or in the future, which arise directly or indirectly by reason of exercise of the authority granted above.

Signature of Parent or Guardian #1: _____ Date: _____ Phone: _____

Print Name of Parent or Guardian #1: _____

Signature of Parent/Guardian #2: _____ Date: _____ Phone: _____

Print Name of Parent or Guardian #2: _____

Signature of Student (If 18 Years of Age or Older):_____ Date: _____

School Nurses: Ashley Morgan, RN and Lauren Gouin, RN School: CATS Academy Boston

Form G - *To be filled out by Parent/Legal Guardian*

Authorization for Administration of Over-The-Counter Medications

Student Name: _____ Date of Birth: _____ Grade: _____

CATS Academy Boston's administrative policies, school physician collaboration and school nurse standards of practice allow us to administer to your child the following over-the-counter (non-prescription) medications including, but not limited to: acetaminophen (Tylenol), antacids (Tums), ibuprofen (Advil, Motrin), and cough drops in an over-the-counter, manufacturer's recommended dosage. These medications are supplied by CATS Academy Boston and kept by the nursing staff.

In order to comply with the regulations of Massachusetts Law and the Board of Registration in Nursing, your written parental permission is REQUIRED for CATS Academy Boston to administer over-the-counter medications to your child. Please complete and return this form. No over-the counter medication can be given without prior written parental authorization.

By signing below, I give permission for the School Nurse to administer over-the-counter medications to my child named above as the School Nurse determines appropriate for my child's health and safety.

If your child has any known allergies, please describe:

_____

I, the undersigned, do hereby solemnly swear that I have the legal custody of my child. I understand and acknowledge that my authorization and permission herein are valid for the duration of my child's time at CATS Academy Boston and can be withdrawn at any time. I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releasees"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releasees, which I or my child or our heirs, legal representatives, successor, conservators and assigns may have, now or in the future, which arises directly or indirectly by reason of exercise of the authorization granted above.

Signature of Parent or Guardian #1: _____ Date: _____ Phone: _____

Print Name of Parent or Guardian #1: _____

Signature of Parent/Guardian #2: _____ Date: _____ Phone: _____

Print Name of Parent or Guardian #2: _____

Signature of Student (If 18 Years of Age or Older):_____ Date:_____

Form H Parental Authorization for Medical Treatment

Student Name: _____ Date of Birth: _____

Parent/Guardian Name #1:_____ Phone Number: _____

Parent/Guardian Name #2:_____ Phone Number: _____

In case of emergency, if the parents cannot be reached, the person listed below should be contacted.

Name: _____ Relationship: _____

Phone Number (Home):_____ _____ Phone Number (Work):_____

Does your child named above have any medical conditions or allergies?
☐ YES ☐ NO If yes please describe: _____

In rare instances, a medical or dental emergency requiring treatment arises in which written consent by parents or guardians is legally required, but the parents or guardians cannot be reached. In this event, and in order to avoid delay that might jeopardize the life or recovery of your child, we request the following permission from parents and guardians, with the understanding that efforts will be made to contact you in case of an emergency.

In my capacity as the custodial parent and/or legal guardian of the child, I hereby appoint CATS Academy Boston and the School Nurse my true and lawful representative for the purposes of taking all steps necessary to ensure the proper care (including medical, dental, surgical, psychiatric and hospital care) of my child while my child is enrolled at CATS Academy Boston, and to execute any and all necessary documents and papers, including consent for treatment forms, requested by any person or entity prior to treatment of or rendering of care to my child.

In authorizing such treatment, I agree to accept the determination of the treating physician, dentist or other medical personnel that the treatment or examination rendered was medically necessary or advisable to protect the life, health or mental well-being of my child. Additionally, I hereby grant my authorization and consent for CATS Academy Boston and the School Nurse to administer general first aid treatment for any minor injuries or illnesses experienced by my child.

By signing below, I authorize CATS Academy and the CATS Academy School Nurse to permit commencement of medical treatment for my child when, in the professional judgment of physician, dentist, or other medical personnel involved, such treatment is medically necessary or advisable, even if I have not yet been consulted, specifically including, but not limited to:

- Obtaining medical treatment and procedures, including surgery and anesthesia, by appropriate health care providers, as needed
- Signing on my behalf for medical treatment, procedures, surgeries, anesthesia, etc.;
- Releasing and obtaining relevant medical or mental health information from health care professionals providing treatment;
- Signing necessary consents and forms when I am not present.
- Obtaining routine medical treatment from appropriate health care providers if symptoms of illness occur (*e.g.,* fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.);
- Obtaining immunizations, PPD tests and physical examinations as required by Massachusetts Law;
- Giving appropriate treatment for minor problems, such as cuts, bruises, sprains, headaches etc.;
- Administering over the counter medications and prescription medications as needed;
- Requesting medical documentation from facilities regarding care given to my child; and/or
- Completing medical claims and speak on my behalf regarding medical bills.

I, the undersigned, do hereby solemnly swear that I have the legal custody of the child. I acknowledge that I have read this document in its entirety and I have satisfied myself that I understand the content of this agreement. By signing below I authorize CATS Academy and the CATS Academy School Nurse to obtain medical treatment for my child and to permit commencement of medical treatment as described above. I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston, the CATS Academy Boston School Nurse, CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releasees"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releasees, which I or my child or our heirs, legal representatives, successors, conservators and assigns may have, now or in the future, which arise directly or indirectly by reason of exercise of the authority granted above.

Print Name of Parent or Guardian #1:_____ Signature: _____ Date: _____

Print Name of Parent or Guardian #1:_____ Signature: _____ Date: _____

(If 18 Years of Age or Older)

Print Name of Student: _____ Signature: _____ Date: _____

CATS ACADEMY BOSTON

Form I - Influenza Vaccine Consent

_____ _____

Student Name Date of Birth

I give permission for my child _____ to receive the influenza vaccine. The influenza vaccine may be administered via injection (inactive injectable influenza) or intranasal (live, attenuated influenza vaccine, LAIV). I have read the Influenza Vaccine Information sheet, and am aware of the risks and potential side effects of the vaccine. I am aware that there is an additional cost for the influenza vaccine and that it will be billed to my child's student account.

I, the undersigned, do hereby solemnly swear that I have the legal custody of my child. By signing below, I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston and CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releasees"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releasees, which I or my child or our heirs, legal representatives, successors, conservators and assigns may have, now or in the future, which arise directly or indirectly by reason of exercise of the authority granted above.

Signature of Parent or Guardian #1: _____ **Date:** _____ **Phone:** _____

Print Name of Parent or Guardian #1: _____

Signature of Parent/Guardian #2: _____ **Date:** _____ **Phone:** _____

Print Name of Parent or Guardian #2: _____

VACCINE INFORMATION STATEMENT

Influenza Vaccine

What You Need to Know

(Flu Vaccine, Inactivated)

2013-2014

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every winter, usually between October and May.

Flu is caused by the influenza virus, and can be spread by coughing, sneezing, and close contact.

Anyone can get flu, but the risk of getting flu is highest among children. Symptoms come on suddenly and may last several days. They can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can make some people much sicker than others. These people include young children, people 65 and older, pregnant women, and people with certain health conditions—such as heart, lung or kidney disease, or a weakened immune system. Flu vaccine is especially important for these people, and anyone in close contact with them.

Flu can also lead to pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine is the best protection we have from flu and its complications. Flu vaccine also helps prevent spreading flu from person to person.

2 Inactivated flu vaccine

There are two types of influenza vaccine:

You are getting an **inactivated** flu vaccine, which does not contain any live influenza virus. It is given by injection with a needle, and often called the "flu shot."

A different, **live, attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

Flu vaccine is recommended every year. Children 6 months through 8 years of age should get two doses the first year they get vaccinated.

Flu viruses are always changing. Each year's flu vaccine is made to protect from viruses that are most likely to cause disease that year. While flu vaccine cannot prevent all cases of flu, it is our best defense against the disease. Inactivated flu vaccine protects against 3 or 4 different influenza viruses.

It takes about 2 weeks for protection to develop after the vaccination, and protection lasts several months to a year.

Some illnesses that are not caused by influenza virus are often mistaken for flu. Flu vaccine will not prevent these illnesses. It can only prevent influenza.

A "high-dose" flu vaccine is available for people 65 years of age and older. The person giving you the vaccine can tell you more about it.

Some inactivated flu vaccine contains a very small amount of a mercury-based preservative called thimerosal. Studies have shown that thimerosal in vaccines is not harmful, but flu vaccines that do not contain a preservative are available.

3 Some people should not get this vaccine

Tell the person who gives you the vaccine:

- **If you have any severe (life-threatening) allergies**. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get a dose. Most, but not all, types of flu vaccine contain a small amount of egg.
- **If you ever had Guillain-Barré Syndrome** (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** They might suggest waiting until you feel better. But you should come back.

U.S. Department of Health and Human Services Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With a vaccine, like any medicine, there is a chance of side effects. These are usually mild and go away on their own.

Serious side effects are also possible, but are very rare. Inactivated flu vaccine does not contain live flu virus, so **getting flu from this vaccine is not possible**.

Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. **Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls.** Tell your doctor if you feel dizzy or light-headed, or have vision changes or ringing in the ears.

Mild problems following inactivated flu vaccine:

- soreness, redness, or swelling where the shot was given
- hoarseness; sore, red or itchy eyes; cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Moderate problems following inactivated flu vaccine:

- Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time may be at increased risk for seizures caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Severe problems following inactivated flu vaccine:

- A **severe allergic reaction** could occur after any vaccine (estimated less than 1 in a million doses).
- There is a small possibility that inactivated flu vaccine could be associated with Guillain-Barré Syndrome (GBS), no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

7 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement (Interim)
Inactivated Influenza Vaccine

07/26/2013

Office Use Only

42 U.S.C. § 300aa-26

Form J - *Serious Allergy Plan*

Student Name	Date of Birth	Grade	Boarding (B) / Day (D)

This form must be completed if your child has a serious allergy that requires an EpiPen.
This form is required to be on file at the Health Center

Allergic to: _____ **Date of Plan**: _____

STEP 1: ASSESSMENT

- ☐ Mouth: itching, tingling or swelling of lips, tongue, mouth
- ☐ Throat: tightening of throat, hoarseness, difficulty talking
- ☐ Lungs: shortness of breath, coughing, wheezing
- ☐ Skin: cool/clammy, hives, itchy rash, swelling of the facial extremities
- ☐ Gut: nausea, abdominal cramps, vomiting, diarrhea
- ☐ Heart: thready pulse, fainting, paleness
- ☐ Emotional: feeling of doom
- ☐ Other: _____

STEP 2: If any of the above symptoms are present and contact with allergen is confirmed or suspected:
ADMINISTER EpiPen 0.30mg via auto-injection into lateral thigh

STEP 3: ACTIVATE EMERGENCY MEDICAL SYSTEM (EMS)
1. Call 911
2. Call extension 2222 to alert Campus Safety

STEP 4: Administer Benadryl orally (check one): ☐ 25mg ☐ 50mg ☐ None

STEP 5: For persistent or worsening signs and symptoms after (check one): ☐ 5 minutes ☐ 10 minutes
Administer second EpiPen 0.30mg via auto-injection into lateral thigh

STEP 6: Call Emergency Contacts

Name	Relationship	Primary Phone	Alternate Phone
1.			
2.			
3.			

PRESCRIBER'S INFORMATION (Doctor or Nurse Practitioner)

Name of Licensed Physician (please print) _____ Phone Number _____

Email Address _____ Fax Number _____

Licensed Physician Signature _____ Date _____

SIGNATURE

Parent/Guardian Signature _____ Date _____