Landmark School
ELEMENTARY • MIDDLE SCHOOL
POST OFFICE BOX 1489 • 167 BRIDGE STREET
MANCHESTER, MASSACHUSETTS 01944-1489
978.236.3100 • FAX 978.526.1482

HEALTH HC CENTER

Health Center Greeting Letter
Academic Year 2009-2010

Dear Landmark Student Parents/Guardians,

Attached are Student Health and Medical Forms pertaining to your child's enrollment for the Landmark School 2009-2010 Academic Year as well as two separate pages that detail Medical Requirements and Medical/Dental Costs.

The completion of the enclosed forms is required in order for registration and enrollment to take place for your child for the Landmark School 2009-2010 Academic Year.

All forms MUST be completed and returned to the Landmark School Health Center no later than **August 1, 2009.**

Any questions or concerns regarding the enclosed Health Forms should be directed to the Elementary/Middle School Health Center.

Students must return:

Parental Authorization to Treat Form
Physical Exam and Immunization Form
Medication Administration & Dental Emergency Form
Meningococcal Waiver or Proof of Vaccination Form
Photocopy of insurance card

EMS Health Center:

Bonnie Corrigan, R.N.
P.O. Box 1489
Manchester-by-the-Sea, MA 01944

Phone: 978-236-3107
Fax: 978-526-1482

Sincerely,

Bonnie Corrigan, R.N.

Medical Requirements
Landmark Elementary•Middle School
Health Center
Academic Year 2009-2010

Directions: Please read the following information carefully. Your child's enrollment in Landmark's programs, including sports, is contingent upon the following requirements.

- **Physical Examination**: A complete physical examination must be obtained some time between May 1st and when your child enters school. It should be reported on the form provided, or one provided by the examining physician. Without this examination, we cannot enroll your child.

- **Record of Immunization**: "An MMR (Measles, Mumps and Rubella) booster and a Tetanus booster are required". *See **SECTION 15** below.

PLEASE NOTE: Failure on the part of parents/guardians to meet these requirements will render us unable to register your child in our programs. This policy applies to ALL students whether new or returning, day or residential, and will be strictly enforced.

*Summer students returning to Landmark in September need not file new examination forms if exams were completed after May 15.

In accordance with the School Immunization Law, Chapter 76, Section 15 of the General Laws of Massachusetts, you are asked to read the following. The Law specifically means a completed IMMUNIZATION RECORD, unless the physician has determined that the child's health would be endangered by these immunizations and has sent a written authorization to that effect.

***SECTION 15**

"No child shall, except as hereinafter provided, be admitted to school except upon presentation of a physician's certificate that the child has been successfully immunized against diphtheria, pertussis, tetanus, measles, and poliomyelitis and such other communicable diseases as may be specified from time to time by the Department of Public Health."

"A child shall be admitted to school upon certification by a physician that he has personally examined such child and that in his opinion the physical condition of the child is such that his health would be endangered by such vaccination or by any of such immunizations. Such certification shall be submitted at the beginning of each school year to the physician in charge of the school health program. If the physician in charge of the school health program does not agree with the opinion of the child's physician, the matter shall be referred to the Department of Public Health, whose decision will be final."

"In the absence of an emergency or epidemic of disease declared by the Department of Public Health, no child whose parent or guardian states in writing the vaccination or immunization conflicts with his sincere religious beliefs shall be required to present said physician's certificate in order to be admitted to school."

If there is a question of your child having been exposed to a contagious disease, please keep him/her at home until your physician gives written permission to return to school.

If your child returns to school with a new medication, or has been seen by a physician for any reason that requires continued care (i.e., illness) a physician's written explanation of diagnosis and treatment MUST accompany your child and be brought to the Health Center to ensure continued and correct treatment. NO VERBAL EXPLANATION BY THE STUDENT WILL BE ACCEPTED.

Medical and Dental Costs

Landmark Elementary • Middle School
Health Center
Academic Year 2009-2010

Landmark provides on-campus nursing services. Any services rendered on campus are provided without cost to the student. Any simple medication normally stocked in the Health Center is also provided without cost.

Landmark does not provide a medical insurance program for students. Because the majority of students are covered under their family health insurance plans, we have found that there is not enough interest to have a student health insurance plan here. Therefore, parents should check their health plans to ensure that their child is adequately protected and should expect to be billed for off-campus medical services provided to their child.

Emergency Treatment

In the case of an emergency, Landmark will arrange transportation to a nearby medical facility. Office calls or emergency room use will be billed by the physician or hospital just as if the child were home. Emergency dental treatment will be billed directly to parents by the dentist/orthodontist. If special prescription drugs are intended for a specific child, they will be billed at actual pharmacy cost.

In an emergency, residential and day students may have access to Dr. Gregory Bazylewicz, the school physician. If your policy requires a referral from your primary care physician prior to treatment, please have your physician write a referral letter to Dr. Bazylewicz in order for him to treat your child if necessary. Please attach this referral letter to the Parent Authorization to Treat Form.

Special Services

Whenever appropriate, psychological or psychiatric services will be billed directly to health insurance plans. Otherwise, special services not covered in the Individual Education Plan may be billed to parents.

Note: A Parent or Guardian must complete and sign this form.

Parental Authorization to Treat Form
Landmark School

Student Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Parent or Guardian: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Work Phone: ( ) _____

Address: _____

If not available, in an emergency contact:

1. _____ Phone: ( ) _____
2. _____ Phone: ( ) _____

Health History: (Circle or fill-in where applicable)

		Allergies		**Food Allergies**		**Diseases**	
Ear Infections	Y N	Hay Fever	Y N	Nuts, Type _____		Chicken Pox _____	
Convulsions	Y N	Ivy Poisoning, etc.	Y N	Beans _____		Measles _____	
Diabetes	Y N	Insect Stings	Y N	Dairy _____		Mumps _____	
Asthma	Y N	Penicillin	Y N	Seafood _____		Rheumatic Fever _____	
Mononucleosis	Y N	Other Drugs	Y N	Other _____			
		Specify _____					

Last Tetanus Booster: _____

Operations or Serious Injuries (Dates): _____

Chronic or Recurring Illnesses: _____

Any Family History of Epilepsy, or Other Neurological or Emotional Disorders: _____

Athletic Information: list any fractures, sprains, concussions or bone dislocations: _____

Psychological climate at home: _____ Psychiatric Counseling? Y N

Does student take medication daily? **If yes, please list medications**: _____

_____

Name of Health Insurance: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's SS Number: _____

Prescription Plan (if applicable): _____

Please copy Both Sides of Insurance Card & Prescription Drug Card and attach to this form, along with a letter of referral from your primary care physician for emergency care, if necessary.

PARENT'S AUTHORIZATION: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed school activities, except as noted by me and the examining physician. I give permission for members of the Landmark School to administer first aid, medications, or any other assistance they consider to be in the best interests of my child. In the event of an emergency, I hereby give permission to the physician selected to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. I hereby authorize the Landmark School physician to examine my child and prescribe medications as he/she deems necessary.

Parent/Guardian Signature: _____ **Date:** _____

Note: A Physician must complete and sign this form.

Physical Exam & Immunization Form

Landmark School

HEALTH HC CENTER

Student Name: _____ Date of Birth: _____

Immunization History

Required immunization must be determined locally. This is a record of dates of basic immunization and most recent booster doses.

DTP Series _____ Booster _____
Polio OPV (Sabin) _____ Booster _____
Measles Vaccine (live) _____
German Measles (Rubella) _____
Smallpox _____
Varicella Vaccine _____ Booster _____
Meningococcal Vaccine _____

Tetanus Booster _____
Typhoid _____
Tuberculin Test _____
Mumps Vaccine (live) _____
Hep B Series 1 _____
2 _____
3 _____

Medical Examination

This examination should be performed between May 1st and when this child enters school, to determine your patient's fitness to engage in athletic or other strenuous activities.

Height: _____ Weight: _____ Blood Pressure: _____ Hemoglobin Test: _____ Urinalysis: _____

Eyes: _____
Ears: _____
Nose: _____
Throat: _____
Teeth: _____s_____
Heart: _____
Lungs: _____
Abdomen: _____

Skin: _____
Hernia: _____
Extremities: _____
Allergy:
Please Specify _____
General Appraisal of Individual and Family: _____
_____
_____

Screening:

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

For Girls:

Has this person menstruated? _____ If not, has she been told about it? _____
If so, is her menstrual history normal? _____ Special Considerations: _____

Sports: Cleared for all sports/PE _____ **Restrictions:** _____
Special Diet: _____
Special Medicines (Please Name): _____
Dosage and Time to be Given: _____
Reason Medication is Being Given: _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in school activities, except as noted above.

Examining Physician Signature: _____ **MD Date:** _____

Telephone: _____ **Address:** _____

Note: A Parent or Guardian must complete and sign this form.

Medication Administration & Dental Emergency Form

Landmark Elementary•Middle School
Health Center
Academic Year 2009-2010

Student Name: _____ Date of Birth: _____

Name of Medication: _____

Dosage: _____

Time given at home: _____

Times to be given at school: _____

Prescribing Doctor's Name: _____

Doctor's Address: _____

Prescription Medication to be given in school requires a written doctor's order. Medication must be brought in or mailed in by an adult caregiver. Medications must be in the original labeled medication bottle.

Student HAS___ DOES NOT HAVE ____ my permission to be given prescription medication by Landmark School staff with a written doctor's order in school.

Student HAS___ DOES NOT HAVE ____ my permission to receive over-the-counter medication from Landmark School staff including first aid topical treatments, pain, cold, cough, allergy, stomach upset relief medication, and EpiPen administration.

Parent/GuardianSignature:_____Date:_____

Dental Emergency Permission

If dental emergencies occur, permission is needed to send your child for dental or orthodontic care.

Landmark Health Center (please check one) _____ _____
HAS HAS NOT

permission to obtain dental care when deemed necessary.

Comments: _____

Parent/GuardianSignature:_____**Date:**_____