

THE TAFT SCHOOL
110 Woodbury Road
Watertown, Connecticut 06795
TEL: 860-945-7762 (Health Center) FAX: 860-945-7766 (Health Center)

Health and Medical History Records
FORMS TO BE COMPLETED AND RETURNED BY JUNE 1, 2012

Date _____

This health record is to be completed by parent(s) or guardian

Student's Name: _____ SS # _____ Birth Date _____

Home Address _____

Student resides with: Both Parents Father Mother Other _____

Father's full name _____ Home Phone (_____) _____

Business Phone (_____) _____

Cell Phone (_____) _____

Mother's full name _____ Home Phone (_____) _____

Business Phone (_____) _____

Cell Phone (_____) _____

Guardian's full name _____ Home phone (_____) _____

Business Phone (_____) _____

Cell Phone (_____) _____

Alternate responsible person (other than parent) to be reached in case of emergency if parent or guardian is unavailable:

Name _____ Relationship _____

Address _____ Phone (_____) _____

Boarding students only - mandatory credit card information (to be used by the health center for doctor or dental visit co-pays, medication, or any other health care related items not covered by insurance):

Credit Card Number _____ Expiration Date: _____ V-Code _____

Name on Card _____ Billing Address _____

This information is strictly for the use of health services in providing necessary health care while you are a student at Taft School. In Loco Parentis: Due to the unique atmosphere of a boarding school, it may be necessary to discuss the health care of students with pertinent faculty members to assure that safe health care is provided and observed when a faculty member is acting in loco parentis.

MEDICAL HISTORY: *(please indicate with dates)*

1. Has candidate had any of the following? When?

Chicken Pox _____	Muscular-skeletal disorder _____
Tuberculosis _____	Asthma _____
Convulsions, Epilepsy _____	Diabetes _____
Ear Trouble _____	Fainting Attacks _____
Malaria _____	Headache/Concussion _____
Heart Disease _____	Speech Difficulty _____
Congenital Defect _____	Kidney Disease _____
Gain or Loss of Weight _____	Menstrual Pain _____
Anxiety / Depression _____	Tumor / Cancer / Cyst _____
Chemical Dependency (drugs / alcohol) _____	Eating Disorder (anorexia/bulimia) _____
Learning Disability _____	Orthodontics _____
Wears glasses or contact lenses _____	(attach copy of prescription)

2. Surgical intervention

3. Serious injuries/hospitalizations

4. Allergy to Food +/- Insect: (please describe reaction and treatment)

5. Allergy to medication (name of medication and reaction)

6. Emotional status

7. Menstrual pattern

8. Psychiatric +/- drug/alcohol treatment

9. Other chronic illnesses _____

List all medications that will be taken while at school. Please have your physician complete medication authorization form(s). Please have your pharmacy package any controlled medication in blister packs.

To the best of my knowledge the above information given is complete and true _____

****Parent's Signature REQUIRED**

**THE TAFT SCHOOL
PHYSICAL EXAMINATION PRIOR TO ENTRY**

PLEASE FILL IN ALL BLANKS, FRONT AND BACK
INCOMPLETE FORMS WILL BE RETURNED TO THE PARENT

Student Name _____ Date of Physical _____

Date of Birth _____ Sex: M _____ F _____

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

Vision: Right 20 / _____ Corrected to 20 / _____ Left 20 / _____ Corrected to 20 / _____
With Glasses yes no With Contacts yes no

* Examination of:	Normal	Abnormal	Comment on all "abnormal" answers
Head & Scalp			
Eyes (and fundi)			
Ears (and hearing)			
Nose			
Mouth & Teeth			
Pharynx			
Neck			
Thyroid			
Skin			
Lymph Nodes			
Breasts			
Lungs			
Heart			
Abdomen			
Genitalia			
Extremities			
Spine & Joints			
Neurologic & Reflexes			
Emotional State			
Nutrition			

*Urinalysis: Albumin: _____ Sugar _____ Microscopic _____

*Hemoglobin or hematocrit _____

A chest x-ray or negative tuberculin test within 6 months prior to entering Taft is **REQUIRED**.

Has patient had BCG in the last 5 years? _____

*Tuberculin test: Type _____ given on ____/____/____ Reaction _____ Read on ____/____/____

If positive, chest x-ray date ____/____/____ and report _____ and treatment _____

*Is this student able to participate in: Sports without restrictions? Sports with restrictions?

Recommendations _____

MD/PA Signature: _____ Address: _____

NAME: _____

...

SPECIAL INFORMATION

A. FAMILY MEDICAL HISTORY

	Age	State of health	Occupation
Father			
Mother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			

B.MEDICATION: note any medication(s) student is now receiving and will continue to receive: _____

***Please have Medication Authorization form filled out for each medication. (Make copies as necessary)**

C. Please record **IMMUNIZATIONS** which have been given with correct dates below: (month and year)

DESCRIPTION	DATES			BOOSTER DATE
* DTP / Td x 4				
* Poliomyelitis x 4 (one dose after age 4 required)				
*Measles x 2				
*Mumps				
*Rubella				
*MMR x 2				
*Varicella				
*Hepatitis B x 3				
*Menactra (meningitis)				
Other				

Disease history of above: _____ (Specify) _____ (Date) _____ (Confirmed by)

***These are mandatory in the State of Connecticut. Your child must have them before enrolling.**

MEDICAL, DENTAL AND PSYCHIATRIC CONSENT FORM

I (we), parent(s) or legal guardian of _____
(Student's name)

Who is a student at The Taft School, Watertown, CT, hereby authorize the Health Center staff at the school to administer to my (our) child any medical/dental/psychiatric care, treatment or medication deemed advisable by a physician licensed by the State of Connecticut or by any other qualified health professional under the general supervision of a licensed physician. I (we) further consent to the immediate transfer of my (our) child to any hospital or other medical facility or office in the event of an urgent or emergent medical, dental or psychiatric condition, and authorize a representative of the school to consent on my (our) behalf to any urgent or emergent medical, dental or psychiatric treatment to be rendered to my (our) child.

I (we) further authorize any physician or health care provider who has rendered treatment to my (our) child to release to the Health Center any and all medical records relating to or necessary for my (our) child's treatment or diagnosis, in order to enable it to provide treatment for the physical and mental health of my (our) child.

I (we) authorize the school to release information to facilitate the medical, dental, psychiatric care of my (our) child or as is necessary to enable the provider of care to complete a claim for health insurance. I (we) understand and agree that I (we) are exclusively responsible for the payment of all medical services rendered to my (our) child other than services provided directly by the health center.

The school assures the parent(s) or legal guardian that all reasonable efforts to contact them will be made before exercising this authorization. This consent will remain in effect as long as our child is a student at Taft.

Date of Birth _____ Tetanus Booster (most current date) ___/___/___

Allergies _____ Medications _____

Chronic Major Illness _____

Today's Date ___/___/___ _____

Parent or Guardian signature

Home phone _____ Business phone _____

Cell phone (_____) _____

Home Address _____

INSURANCE INFORMATION (U.S. STUDENTS ONLY - COPY OF BOTH SIDES OF INSURANCE CARD REQUIRED)

Insurance company _____

Insurance Co. address _____

Employer providing insurance _____

Primary Group # _____ Membership ID # _____

Policy Holder _____ Date of Birth ___/___/___

Policy Holder SS# ___/___/___ Relationship to student _____

Parents of **boarding students** must complete the following form. Please note that ALL medications will originate from the Health Complex Pharmacy. They will submit all claims to the Insurance company and bill your credit card for the co-pay amount. It is your responsibility to update all Insurance changes immediately with Health Complex. It is Health Complex's intention to bill all eligible prescriptions to your Insurance company. However, in the event that Health Complex does not have the current insurance information for billing, they will charge your credit card for the normal and customary prescription charge.

HEALTH COMPLEX PHARMACY
CHARGE ACCOUNT APPLICATION

Student Name _____ Birthdate ___/___/___ SS # _____

Address _____ Phone _____ Age ____ Sex ____

City/State/Zip _____ Email _____

Student Medication Allergies _____

Custodial Parent: Father ____ Mother ____ Both ____ Other _____

Father's Full Name _____ Res. Phone _____

Bus. Phone _____

Mother's Full Name: _____ Res. Phone _____

Bus. Phone _____

Guardian's Full Name _____ Res. Phone _____

Bus. Phone _____

Name of Prescription Insurance Company _____ Phone _____

ID # _____ Group # _____

Subscriber's Name _____

Please return this application to the Taft Student Health Center prior to your child's arrival to the school. It will be forwarded to the Health Complex Pharmacy. Be sure to attach a copy of your prescription plan card, both sides, enlarged, readable.

****Expiration date must be valid for the next three months. If not listed or date expired, the pharmacy cannot process the charges. PLEASE NOTIFY US OF NEW CARD NUMBERS AND EXPIRATION DATES.**

Co-pay charges: A valid credit card and expiration date must be given.

(Circle one) Mastercard Visa American Express Discover

Card # _____ Expiration Date _____ V-Code _____

Name on Card _____ Billing Address _____

I hereby give my permission to charge the above credit card for the co-pay or normal and customary amount of my child's prescriptions.

Signed: _____

Send changes of health insurance coverage to: Health Complex Pharmacy Fax #860-945-1728 or call 860-274-8816



The Taft School

Martin Health Center, 110 Woodbury Road, Watertown, CT 06795
Phone: 860-945-7762 Fax: 860-945-7766

AUTHORIZATION FROM PHYSICIAN/DENTIST FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL:

The Connecticut State Law and Regulations require a physician's or dentist's written order for a nurse to administer medications. Medications must be in pharmacy-prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name, and date of original prescription.

PHYSICIAN'S OR DENTIST'S ORDER:

Name of Child _____ Date _____

Address _____ Date of Birth _____

Condition of which drug is being administered at school _____

DRUG: Name, dose, and method of administration _____

Time of administration _____

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

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Physician's or Dentist's Name _____
(type or print)

Address _____

Telephone # _____ Fax # _____

Physician's or Dentist's Signature _____

AUTHORIZATION FROM PARENT/GUARDIAN For the administration of above medication by school personnel:

Date _____

To School Personnel:

I hereby request that school personnel administer the above medicine, ordered by the physician/dentist for my child. I understand that I must supply the school with the prescribed medication in the original container dispensed and supply of said medicine. I further understand that this 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 school.

NAME (Print) _____ Signature _____

Address _____

Relationship to child _____ Phone # _____