



STUDENT HEALTH HISTORY

TO BE COMPLETED BY PARENTS

(Print) Student's Last Name	First Name	Middle Name	Date of Birth	Religion
Street Address	City	State	Zip Code	Home phone
Program				

FAMILY HISTORY

	Gender	Age	State of Health	Occupation	Age At Death	Cause of Death
Parent 1						
Parent 2						
Sibling 1						
Sibling 2						
Sibling 3						
Sibling 4						

HAVE ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING:

	Yes	No		Yes	No
Tuberculosis			Epilepsy, Convulsion		
Diabetes			Cancer		
Kidney Disease			Stomach/Intestinal Trouble		
Heart Disease			Emotional Instability		
Heart attack before age 50			Bipolar Disorder		
High Cholesterol			Alcoholism		
Arthritis			Schizophrenia		
Digestive Disease			Eating Disorder		
Asthma, Hay Fever					

Please Provide Additional Details Below:

Menstrual History (For Women Only)	Yes	No		Yes	No
Irregular Periods			Regulation Medication(s)		
Severe Cramps			Other Concerns:		

Describe Flow (please circle)	Light	Normal	Heavy
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Age of Onset: _____ Duration of Period: _____ Interval Between Periods: _____

WALNUT HILL SCHOOL -- HEALTH CENTER 12 HIGHLAND STREET NATICK, MA 01760 Tel: (508) 650-5030 Fax: (508) 650-5043
 Name _____ Program _____

STUDENT HEALTH HISTORY

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Page 2: Health History

Has the student had any illness or been hospitalized other than already noted? Yes____ No____

Please describe_____

Has the student received treatment or counseling for any psychological or social issues? Yes____ No____

Please describe_____

Has the student ever been immunized against tuberculosis with BCG vaccine? _____

Has the student needed any medical intervention besides regular check-ups in the past 5 years? Yes____ No____

Please describe_____

Does the student have any **CHRONIC or LIFE-THREATENING** conditions? Yes____ No____

Please describe_____

Has the student ever been hospitalized for any medical conditions? Yes____ No____

Please describe_____

Is the student receiving continuing medical treatment? Yes____ No____

Please describe_____

Does the student take **medications** on a DAILY or REGULAR basis? (prescription **or** over-the-counter?) Yes____ No____

Please list medication and complete the "Parent/ Guardian Consent for Medication Administration" form

Does the student have any **ALLERGIES**, i.e. medications, foods, environmental substances, insect stings etc.? Yes__No__

Please describe:

Allergy Trigger	Typical Reaction	Treatment

Does the student carry an **EpiPen**? Yes____ No____

Note: Students who carry EpiPens will need to bring **TWO pens to Walnut Hill (one to keep with them at all times and one for the dorm)*

Other Emergency Contacts: *Please note that every attempt will be made to contact you in the event of an unexpected illness or injury. If we are unable to reach you, we will contact the person listed below.*

Name_____ Phone_____

Relationship_____ Address_____ City_____ State_____

Name_____ Phone_____

Relationship_____ Address_____ City_____ State_____



Name _____ Program _____

STUDENT HEALTH HISTORY

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Page 3: Health History

If the student has experienced any of the following health concerns, please describe the treatment(s) used and give appropriate dates:

Medical Concern	Yes	No	Comments- Treatment and Approximate Dates
Cardiac Disorder			
Seizures/ Neurological Disorder			
Diabetes/ Metabolic Disorder			
Bleeding Disorder			
Hospitalization/ Surgery			
Asthma/ Respiratory Disorder			
Chronic Illness			
Visual Deficit/ Eye Disorder			
Speech Deficit/ Throat Disorder			
Diet Restrictions, Digestive Dis.			
Eating Disorders			
Orthopedic Disorder			
Menstrual/ Genitourinary Dis.			
Chicken Pox			
Mononucleosis			
Other			
Psycho/Social Concerns			
ADD/ADHD			
Other Psychological diagnoses			
History of Psychiatric Admissions			
History of Self-Injurious behavior			

As the parent/legal guardian of this student, I have answered these questions honestly and to the best of my knowledge. I understand that any withheld or falsified information could be damaging to my students' health and could lead to withdrawal from the Walnut Hill School summer program.

Signature _____ Date _____



WALNUT HILL

PHYSICAL EXAMINATION BY LICENSED PROVIDER

PARENTS: PLEASE KEEP A COMPLETED COPY OF THIS FORM

Walnut Hill School requires that all program participants provide documentation of a physical examination within twelve (12) months preceding their initial arrival at school. This form is to be completed by a **Licensed Care Provider**. Both sides must be completed. We ask that the licensed care provider advise us of any health concerns, allergies, dietary or activity restrictions. Please be specific and use the space provided on the reverse side if more space is needed.

NOTE: The student has been accepted to the summer program. Information supplied will not affect acceptance status and will be used for providing health care. This information is strictly for the use of Health Services and will not be released without consent.

I have examined _____ **on** _____
Patient's name Date of Exam

IMMUNIZATION HISTORY: Please record the dates (month/year) of basic immunizations and most recent booster:

VACCINE	DATES				
DPT					
Td					
OPV/IPV					
MMR					
Hib					
Hepatitis B					
PPD/Mantoux					
Varicella					
Meningitis					
Other(s)					

For International Students only (PPD required within the last year)

TB/ PPD date	Results (mm)	Treatment (required if >5mm, regardless of BCG)

PHYSICAL EXAMINATION:

HEIGHT	WEIGHT	BMI	PULSE	RESPIRATIONS	BP

SYSTEM	NORMAL	COMMENTS AND/OR CONCERNS
General Appearance		
Skin		
Eyes/ Vision		
Ears/ Hearing		
Nose		
Mouth/ Teeth		
Cardiovascular		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurologic		
Development		
Other		



Name _____ Program _____

PHYSICAL EXAMINATION BY LICENSED PROVIDER

Page 2: Physical Examination

ALLERGY HISTORY:

Does the patient have any allergies? Yes _____ No _____
Does the patient carry an EpiPen? Yes _____ No _____

Note: Patient will need to come to school with **TWO EpiPens*

Please describe allergen, typical response and treatment plan.

Allergen	Typical Reaction	Treatment

Additional information for the health center to be aware of (dietary restrictions, activity restrictions, etc.):

Please list any medications taken by the patient on a daily or regular basis: (Prescription and/or over-the-counter) Complete a "Health Center Medication Order Form" for EACH prescription medication.

VALIDATION OF EXAMINATION: In my opinion the above individual may participate in an intensive arts program with noted restriction.

Name of licensed M.D. completing Physical Examination: _____

Date of Exam: _____ Address: _____ City: _____

PHONE: _____ Fax: _____

Licensed M.D. Signature: _____ Date: _____



CONSENT TO ADMINISTER MEDICATION
MUST BE FILLED OUT COMPLETELY BY PARENT OR GUARDIAN AND STUDENT

STUDENT NAME: _____

MEDICATION POLICY AGREEMENT (ALL PARENTS SIGN)

I have read and understand the Medication Policy at Walnut Hill and agree to abide by its guidelines. I have reviewed the guidelines with my child. I understand that my child cannot possess any medication (over the counter, herbal, natural remedies or prescription) without receiving permission from Health Center staff. Parents/guardians are responsible for promptly updating the Health Center with any changes in medications or as new medications are prescribed. I understand that I may retrieve the medication from the school at any time and that the medicine 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.

(parent/guardian signature) (date)

PRESCRIPTION MEDICATION ADMINISTRATION CONSENT (ONLY IF ON PRESCRIPTION MED)

I give permission for the School Nurse, or school personnel designated by the School Nurse, to give the following medications listed below, prescribed by _____ to my child (noted above).

(parent/guardian signature) (date)

Please list all prescription medications the student is receiving, including those given during the school day:

- 1. _____ 2. _____
- 3. _____ 4. _____

My son/daughter is known to have the following allergies:

OVER THE COUNTER MEDICATION ADMINISTRATION (ALL PARENTS SIGN)

I give permission for the Health Center staff to administer over the counter medications to my child according to guidelines approved by the School Physician and Director of Health Services. If my child is a boarding student, over the counter medications may be administered by staff designated by the Director of Health Services.

(parent/guardian signature) (date)

PARENT CONSENT FOR SELF-ADMINISTRATION OF MEDICATION (ALL PARENTS SIGN)

I give permission for my child to self-administer medication, provided that the school nurse determines it is safe and appropriate. I feel comfortable that my child can responsibly administer him/herself medications. Walnut Hill School will provide support and teaching to students taking medication but does not assume responsibility for students who do not self administer medications (prescription, over the counter, or natural/herbal remedies) as prescribed by the physician or nurse; or as agreed upon in the medication plan.

(parent/guardian signature) (date)

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION (ALL STUDENTS SIGN)

- 1. I understand that I am responsible for taking medications as directed.
- 2. I will safely store the medications and keep it packaged as the school nurse directs. I will report lost medication to the school nurse immediately.
- 3. I agree to contact an adult on campus if I don't feel well or if I have a question about my medication.
- 4. I agree to NEVER share my medication with anyone.
- 5. I agree to NOT keep medications in my dorm room or on my person unless authorized to do so by the Health Center
- 6. I understand that not following these guideline may result in a Disciplinary Committee Hearing.

(student signature) (date)



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Person or Organization authorized to receive the information:

WALNUT HILL SCHOOL • HEALTH CENTER
12 HIGHLAND STREET
NATICK, MA 01760
Tel: (508) 650-5030 Fax: (508) 650-5043

Person whose information is to be released:

Student's Name: _____

Student's Social Security #: _____

Student's Date of Birth: _____

In order to allow direct communication, in accordance with new HIPAA guidelines, between the Walnut Hill School Health Center and any outside providers I (my child) may see while a student at Walnut Hill School, I hereby authorize the use or disclosure of my (my child's) individually identifiable health information (IIHI) disclosed from any health care providers in the USA or as described below to the Walnut Hill School Health Center.

This authorization includes all records concerning diagnosis, treatment, prognosis and opinions as to the above person's condition as this relates to the below listed purpose for the duration of time that said person is a student at Walnut Hill School.

In addition to providing copies, the person or organization authorized to provide IIHI is also authorized to orally discuss over the phone the information listed above with a representative of the Walnut Hill School Health Center.

Purpose of Disclosure:

- To allow communication in order to facilitate coordinated health care.
- In loco parentis.
- Other:

Important Information About Your Rights:

I understand that I may revoke this Authorization by sending a written notice to the party providing my (my child's) IIHI. Revocation of this Authorization will be valid when received by such party, except to the extent that action has been taken relying on it.

I also understand that all health information will remain confidential and known to only those involved with my child's health care. To ensure appropriate care of my (my child's) health, occasionally, it may be necessary to share important health information with Dorm Parents, the Dean of Students or other adults directly involved with the student.

Student's Signature (if 18 years old or older) _____
Date

Parent/Guardian's Signature (if student is younger than 18 years old) _____
Date



MEDICATION ORDER FOR PRESCRIBED MEDICATIONS

**To be completed only if a student is taking PRESCRIBED medications.
Please make as many copies of this form as needed (one per prescription).**

WALNUT HILL HEALTH CENTER MEDICATION ORDER

(to be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Student Name: _____ Date of birth: ____ / ____ / ____

Street Address: _____ Grade: _____

City: _____ State: _____ Zip: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____

Diagnosis requiring medication: _____

Specific directions or information for administration: _____

The date of the next scheduled visit or when advised to return to the prescriber: _____

Consent for self-administration (provided that the School Nurse determines it is safe and appropriate):

___ YES

___ NO

Date of order: _____ Discontinuation Date: _____

Name of Licensed Prescriber (print) _____

Business Telephone: _____ Emergency Telephone: _____

Signature: _____ Date: _____



WALNUT HILL SUMMER PROGRAMS
12 HIGHLAND STREET
NATICK, MA 01760

This health record is to be completed by the parent(s) or guardian(s): please complete all sections.

1. Address	Student's Full Name: _____ Birth Date: _____	
	SS#: _____ Student's Cell: _____	
	Student resides with: _____ Both parent/ guardians _____ Parent/ Guardian #1 _____ Parent/ Guardian #2	
	Parent/ Guardian #1	Parent/ Guardian #2
	Full Name: _____	Full Name: _____
	Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____	
Phone (home) _____	Phone (home) _____	
(cell) _____	(cell) _____	
(work) _____	(work) _____	
(fax) _____	(fax) _____	

2. Medical	Critical Medical Information
	Date of last Tetanus Inoculation: _____
	Allergies: _____
	Pertinent Medical Information: _____
	Although this information is recorded elsewhere, this particular form goes with the student to a doctor's appointment or the hospital in case of emergency. In many situations, time is of the essence and having critical information repeated here will speed up the process. For this reason, please do not refer us to other information on file.

3. Authorization	Authorization For Testing and Treatment of Minors
	The undersigned hereby authorizes and grants the faculty/staff of Walnut Hill School permission to administer care and treatment for:

	(Full Name of Student)
	I, _____ bearing the relationship of _____
(Name of Parent or Guardian)	(Mother, Father, Legal Guardian)
and having legal custody of the above-named student, do consent to the performance of any and all diagnostic and therapeutic testing, procedures, care, (including, but not limited to, X-ray examination, anesthetic, medical or surgical treatment, drug screening, hospital care and psychological, psychiatric and academic counseling and testing) to be rendered to the minor under the supervision of Walnut Hill School. In that regard, I hereby appoint Walnut Hill School of Natick, Massachusetts, to act in my behalf in authorizing any and all of the testing, procedures and care given under this Authorization. I understand that I will be responsible for the cost of any tests, procedures or treatment performed hereunder.	

I give permission for mandatory immunizations as required for school attendance by the School Immunization Law, Chapter 76, Section 15 of the general laws of Massachusetts.

Every effort will be made to contact the parent or guardian prior to any standard procedure. Only in an emergency would the school act prior to notifying the parents of any medical testing or treatment to be performed.

Signature of Parent or Guardian: _____ Date: _____



SUMMER EMERGENCY INFORMATION 2010

Student Name _____

INSURANCE: Walnut Hill School requires that all students have comprehensive medical insurance, and that this information be provided each year.

Name of Subscriber: _____ Subscriber Date of Birth ____ / ____ / ____

Is pre-authorization necessary for any type of treatment? Yes ____ No ____ Phone: _____

PRIMARY CARE PROVIDER : _____

Address: _____ Phone: _____

Please attach a photocopy of the front of the insurance card **in the space below**: (Please do not attach a full page photocopy to the back of this sheet.)

Front of insurance card here.

Please attach a photocopy of the back of the insurance card **in the space below**: (Please do not attach a full page photocopy to the back of this sheet.)

Back of insurance card here.

****A photocopy of this form shall be as valid as the original****