



May 2017

Dear Parents/Guardians,

We would like to take this opportunity to welcome you to Presentation of Mary Academy and to explain the nursing services offered. The Nurse's office is located in Room 1-4, downstairs from the foyer. A nurse will be in the office from 7:45 a.m. to 2:15 p.m. each day. A nurse is available to administer first aid and emergency care to students, to provide health counseling to students, parents, and school personnel, and to educate students, families, and staff about health problems, health care, and self-care.

One of the integral functions of the school nurse is to keep an updated health record for each student. Enclosed are three health forms that need to be completed and returned to the school by August 16, 2017. **If your daughter's/son's health record does not contain these three completed forms he/she may not be able to begin school.**

1. **Physical examination form**

Must be completed by a physician. Please be sure that the form is completed with Immunization record dated, (a list of all necessary immunizations are included in this packet), which includes scoliosis screening. **Any student participating in a school sport MUST have a current physical on file before the start of the sport season. The MIAA requires the physical to be done within 13 months of the first day of the sport season.**

2. **Health History Form**

Parents/Guardians must complete this form. Please indicate any sports your daughter/son has an interest in participating in throughout the year.

3. All new students must have either a TB test or a low risk assessment complete within one year of entry. Massachusetts Department of Public Health low risk assessment is included on the Physical Exam Form.

4. **Consent for Approved Discretionary Medications:** Under our physician's order, we are able to administer a limited amount of over-the-counter medications.

5. All athletes must have a signed permission slip to participate in a sport and a concussion packet completed and signed by parent and student. Concussion Packets can be found on our schools website.

Aside from the over-the-counter medications that are clearly stated on the form, **NO medication will be administered without a specific doctor's order.** If a student needs medication during school hours, either on a regular schedule or as needed, he/she will need a doctor's order for each medication. This includes short-term medication administration, such as antibiotics. Any medication that is necessary during the school day should be delivered to the nurse **with** an order from the doctor. An inhaler that a doctor has ordered to be carried by the student is the only medication a student may carry.

If you have any health concerns or questions, please feel free to call the Nurse's office, (978) 682-9391 X114. Thank you.

Respectfully,

Janice MacDonald, RN

# Massachusetts School Immunization Requirements 2017-2018

## Grades 7-12

Requirements apply to all students including individuals from another country attending or visiting classes or educational programs as part of an academic visitation or exchange program. In ungraded classrooms, grade 7 requirements apply to all students >12 years. Requirements apply to all students, even if over 18 years of age.

<b>Tdap</b>	<b>1 dose;</b> and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at >7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td should be given if it has been £10 years since Tdap.
<b>Polio</b>	<b>4 doses;</b> 4 <sup>th</sup> dose must be given on or after the 4 <sup>th</sup> birthday and >6 months after the previous dose, or a 5 <sup>th</sup> dose is required. 3 doses are acceptable if the 3 <sup>rd</sup> dose is given on or after the 4 <sup>th</sup> birthday and >6 months after the previous dose. In a mixed OPV/IPV schedule at least 4 doses are required, regardless of age.
<b>Hepatitis B</b>	<b>3 doses;</b> laboratory evidence of immunity acceptable
<b>MMR</b>	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be given >28 days after dose 1; laboratory evidence of immunity acceptable
<b>Varicella</b>	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and 2 <sup>nd</sup> dose must be given >28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable
<b>Meningococcal</b>	<b>1 dose;</b> 1 dose MenACWY (formerly MCV4) required for newly enrolled full-time students attending a secondary school with grades 9-12 (in ungraded classrooms, those with students >13 years) who live in a congregate living arrangement approved by the secondary school (e.g., dormitory). Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided by their institution. Meningococcal B vaccine is not required and does not meet this requirement.

## College

Requirements apply to all full-time undergraduate and graduate students, all full and part-time health science students and any full or part-time students attending any postsecondary institution while on a student or other visa, including foreign exchange students attending or visiting classes as part of an academic visitation or exchange program.

<b>Tdap</b>	<b>1 dose;</b> and history of a DTaP primary series or age appropriate catch-up vaccination. Tdap given at >7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catchup schedule. Td should be given if it has been >10 years since Tdap.
<b>Hepatitis B</b>	<b>3 doses;</b> laboratory evidence of immunity acceptable
<b>MMR</b>	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be given >28 days after dose 1; laboratory evidence of immunity acceptable. Birth before 1957 is acceptable for non-health science students.
<b>Varicella</b>	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and 2 <sup>nd</sup> dose must be given >28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable. Birth before 1980 in U.S. is acceptable only for non-health science students.
<b>Meningococcal</b>	<b>1 dose;</b> 1 dose MenACWY (formerly MCV4) required for newly enrolled full-time undergraduate and graduate students in a degree program at a postsecondary institution (e.g., college) who will live in a congregate living arrangement approved by the institution (e.g., dormitory). Students may decline MenACWY vaccine after they have read and signed the MDPH Meninacoccal Information and Waiver Form provided by their institution. Meningococcal B vaccine is not required and does not meet this requirement.

\* A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee.



# PHYSICAL EXAMINATION FORM 2017-2018

## MUST BE COMPLETED BY THE PHYSICIAN

(ALL lines MUST be completed)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

VACCINE	DATE	VACCINE	DATE	VACCINE	DATE	CHICKEN POX
DTP/DtaP/DT	1	OPV/IPV	1	HIB	1	Check here for reliable history of chickenpox:
	2		2		2	
	3		3		3	VARIVAX 1
	4		4		4	2
				Hepatitis B	1	
Adult Td	1	MMR	1		2	Gardasil 1
	2		2		3	
Tdap	1			Hepatitis A	1	3
	2	Meningococcal	1		2	

TUBERCULIN TEST: PPD date \_\_\_\_\_ PPD Reading date \_\_\_\_\_ PPD Results \_\_\_\_\_ mm  
 TB risk factors (exposure, travel to TB countries, foreign born parent): \_\_\_\_\_ Med High Risk \_\_\_\_\_ Low risk  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

**Allergies/Sensitivities:** \_\_\_\_\_

Present Health Concerns & Medications: \_\_\_\_\_

Significant Past Illness or Injury: \_\_\_\_\_

Nutritional Status: \_\_\_\_\_

Eyes R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Glasses Y / N Ears R \_\_\_\_\_ L \_\_\_\_\_

Nose: \_\_\_\_\_ Mouth: \_\_\_\_\_ Teeth: \_\_\_\_\_ Throat: \_\_\_\_\_

Skin: \_\_\_\_\_ Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Liver: \_\_\_\_\_ Spleen: \_\_\_\_\_ Hernias: \_\_\_\_\_

Scoliosis Screen: \_\_\_\_\_

Posture/Spine \_\_\_\_\_ Neck: \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_ Neurological: \_\_\_\_\_ Genitalia: \_\_\_\_\_

Able to Participate in Athletics/Sports: \_\_\_\_\_

Specific Recommendations for Participation: \_\_\_\_\_

DATE OF EXAM: \_\_\_\_\_ PHYSICIAN'S NAME: \_\_\_\_\_

Please Print

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MUST BE RETURNED NO LATER THAN AUGUST 16, 2017**



# HEALTH HISTORY FORM 2017-2018

MUST BE COMPLETED BY PARENT/GUARDIAN FOR EACH STUDENT EACH YEAR

(ALL lines MUST be completed)

Student's Name: _____ Grade _____ Date of Birth: _____		
Mother's Name: _____		Telephone #: _____
Work Number: _____		Cell Number: _____
Address/Town/State/Zip Code: _____		
_____		
Father's Name: _____		Telephone #: _____
Work Number: _____		Cell Number: _____
Address/Town/State/Zip Code: _____		
_____		
1. Does your child have any allergies? _____ Explain: _____		
_____		
2. Does your child wear contact lenses, glasses or both? Yes _____ No _____ Both _____		
3. Does your child take any medication now? _____ If so complete below:		
Medication: _____		Reason for taking medication: _____
_____		
_____		
4. List any operations, fractures, sprains, or bone dislocations.		
_____		Date or Age _____
_____		Date or Age _____
_____		Date or Age _____
5. List any medical or emotional conditions & treatments, past and/or present.		
<b>All medical concerns, conditions and allergies (drug and/or food) MUST BE LISTED</b>		
I hereby give permission to inform faculty of all medical concerns in case of an emergency.		
Parent/Guardian Signature: _____		
1. _____		
2. _____		
3. _____		
6. Do you know any reason for your child not to participate in any sports or gym related activities throughout the school year?		
_____		
_____		
Permission is given for my daughter/son to participate in <i>Voluntary Gym Classes and activities throughout the school year.</i> (i.e., dodgeball, relay race, and outdoor activities on school grounds)		
Parent Signature: _____		Student Signature: _____

209 Lawrence St.; Methuen, MA 01844-3884 Tel: 978-682-9391 Fax: 978-975-3595

MUST BE SIGNED BY PARENT OR GUARDIAN AND RETURNED BY AUGUST 16, 2017



# Health History Check-Off List

To be completed by Parent or Guardian

Has your daughter/son ever had any of the following?  
Please Circle Y for YES and N for NO.

a. Anxiety/Depression	Y	N	m. Mononucleosis	Y	N
b. Asthma	Y	N	n. Panic Attacks	Y	N
c. Allergies	Y	N	o. Cancer	Y	N
d. Fainting	Y	N	p. Pneumonia	Y	N
e. Heart Murmur/Condition	Y	N	q. Hepatitis	Y	N
f. Rheumatic Fever	Y	N	r. ADD/ADHD	Y	N
g. Kidney Disease or Injury	Y	N	s. Meningitis	Y	N
h. Migraine Headaches	Y	N	t. Concussion/Head Injury	Y	N
i. Diabetes	Y	N	u. Seizure Disorder	Y	N
j. Menstrual Problems	Y	N	v. Serious Dental Problems	Y	N
k. Blood Disorders	Y	N	w. Tumors	Y	N
l. Arthritis/Joint Tenderness	Y	N	x. Bridges/False Teeth	Y	N

**INSURANCE COMPANY:** \_\_\_\_\_

**INSURANCE SUBSCRIBER:** \_\_\_\_\_

**POLICY Number:** \_\_\_\_\_ **GROUP NUMBER** \_\_\_\_\_

**PHYSICIAN'S NAME:** \_\_\_\_\_

**PHYSICIAN'S ADDRESS:** \_\_\_\_\_

**PHYSICIAN'S PHONE NUMBER:** \_\_\_\_\_

In case of a medical emergency, I give permission for my daughter/son to be transported by ambulance to the hospital with a PMA Staff member. I understand that the ambulance service is chosen by the hospital.

**PARENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



# Consent for Administration of Approved Discretionary Medications 2017 - 2018

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Allergies/Sensitivities \_\_\_\_\_  
\_\_\_\_\_

Current Medications (including inhalers) \_\_\_\_\_  
\_\_\_\_\_

Medical Conditions \_\_\_\_\_  
\_\_\_\_\_

I hereby give permission for my child \_\_\_\_\_ to receive any medication listed below on the form as deemed necessary by the school nurse. I have checked those medications I wish to be made available to my child. I understand that the generic equivalent of medications may be used.

Please check any medication you wish to be made available to your child:

(For cold, headache, dental discomfort, muscular aches, pre-menstrual or menstrual pain, fever & sore throat)			
_____	Acetaminophen (like Tylenol 325mg)	[ ] 2 tablets	[ ] 3 tablets (Every 4 hours)
_____	Ibuprofen (like Advil 200 mg)	[ ] 2 tablets	(Every 6 hours)

- \_\_\_\_\_ Ointment (like: Bacitracin) For cuts and scrapes
- \_\_\_\_\_ Anti-itching lotion (like: Calamine) For bites/allergic rashes
- \_\_\_\_\_ Chewable antacid tablets (like: Tums) For upset stomach
- \_\_\_\_\_ Cough drops

I understand that the above medications I have checked will be administered by the school nurse in accordance with established protocols developed by the consulting school physician for Presentation of Mary Academy and the school nurse.

\_\_\_\_\_ ***I do not want any medication given to my child in school.***

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work/Emergency Phone

<b><u>Other Person(s) to be notified in case of a medication emergency</u></b>		
_____ Name	_____ Telephone #	_____ Relationship to Student
_____ Name	_____ Telephone #	_____ Relationship to Student