May 2016

Dear Parents/Guardians,

Please keep in mind that before we begin the 2016-17 school year, physicals are mandatory for all incoming freshman, juniors and anyone who wants to play a sports. First, let's explain the function of the PMA school nurse. The nurse's office is located in Room 1-4, downstairs from the foyer. A nurse will be in the office from 8:00 a.m. to 2:00 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 19, 2016. **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 school's 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 meditation 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

Janice MacDonald, RN

Dear Parent/Guardian,

The Massachusetts Department of Public health requirements for **2016 - 2017** school year are as follows:

Vaccine	Requirement
DPaP/DTP/DT/Td Diphtheria/Tetanus/Pertussis	4 doses DTaP/DTP or 3 does Td ***PLUS Tdap or Td booster if greater than 5 years since last dose**
Polio	at least 4 doses. Last dose after 4th birthday
MMR Measles/Mumps/Rubella **1st dose must be after 1st birthday**	2 doses Measles 1 dose Mumps 1 dose Rubella
Hepatitis B	***3 doses***
Varicella/Chickenpox	*** Physician certified reliable history of Chickenpox or Varicella vaccine**** (if younger than 13 years old, one dose; if older than 13 years, two doses.)*

***Additional requirements:**

1. Physician interpretation of parent/guardian description of Chickenpox.
2. Physician diagnosis of Chickenpox or Serological proof of immunity.
3. A Meningococcal Vaccination is required for all residential students or a waiver must be signed by a parent or legal guardian.

If you have any questions, please call the Nurse's office at Presentation of Mary Academy 978-682-9391 x114

Thank you,

Janice MacDonald, RN

PHYSICAL EXAMINATION FORM 2016-2017

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
	2			2			2		history of chickenpox:
	3			3			3		VARIVAX 1
	4			4			4		2
						Hepatitis B	1		
Adult Td	1		MMR	1			2		Gardasil 1
	2			2			3		2
Tdap	1					Hepatitis A	1		3
	2		Menactra	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:_____________________________________

Musculosketetal:__________________ 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 19, 2016

HEALTH HISTORY FORM 2016-2017

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.

All medical concerns, conditions and allergies (drug and/or food) MUST BE LISTED

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 *Voluntary Gym Classes and activities throughout the* school year. (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 19, 2016

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. Asthma	Y	N	l. Mononucleosis	Y	N
b. Allergies	Y	N	m. Cancer	Y	N
c. Fainting	Y	N	n. Pneumonia	Y	N
d. Heart Murmur/Condition	Y	N	o. Hepatitis	Y	N
e. Rheumatic Fever	Y	N	p. ADD/ADHD	Y	N
f. Kidney Disease or Injury	Y	N	q. Meningitis	Y	N
g. Migraine Headaches	Y	N	r. Concussion/Head Injury	Y	N
h. Diabetes	Y	N	s. Seizure Disorder	Y	N
i. Menstrual Problems	Y	N	t. Serious Dental Problems	Y	N
j. Blood Disorders	Y	N	u. Tumors	Y	N
k. Arthritis/Joint Tenderness	Y	N	v. 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 2016 - 2017

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

<u>Other Person(s) to be notified in case of a medication emergency</u>

Name	Telephone #	Relationship to Student
Name	Telephone #	Relationship to Student