Killington Mountain School

2708 Killington Road
Killington, VT 05751
Tel: 802-422-5671 Fax: 802-422-5678

2016 - 2017 Health Form

This health record must be completed and signed by a parent or guardian. The completed form must be returned to the office, Killington Mountain School, 2708 Killington Rd., Killington, VT 05751 before participation in the program

Student Name_____ Birth date_____
first middle last month day year

Home Address _____
street

_____
city state zip

Parent #1 name

Home phone_____

Cell phone_____

Work phone_____

Email_____

Parent #2 name

Home phone_____

Cell phone_____

Work phone_____

Email_____

Alternate responsible person to be contacted in case of emergency if parent or guardian is not available

Name_____ Contact Number_____

Insurance Information

My child is covered by medical/hospitalization and/or accident insurance under the following policy. I understand that this information will be used in the event of sickness, accident or hospitalization. I authorize the release of any medical/pharmacy information necessary to process a claim for payment. **Please attach a copy of the front and back of your insurance card.**

Name of insured parent_____

Insured's employer_____

Insurance plan name_____ Phone number_____

Address_____

Group number_____

Insured's identification number_____

Is there an additional insurance policy? ❑ No ❑ Yes If yes, name

*** Please include a copy of the *front and back* of your insurance card ***

KILLINGTON MOUNTAIN SCHOOL

Release of Information

I, as the parent or guardian of _____, acknowledge that Killington Mountain School has received health information and records regarding my child from his/her physician. I further give permission for my child's physician _____ to release information regarding immunizations, medications and health concerns to Killington Mountain School regarding my child.

I hereby authorize faculty members, nurses, athletic trainers, administrators and coaches and employees of Killington Mountain School and its affiliates to receive, review, discuss and disclose my child's health information and record to others at Killington Mountain School, if necessary for my child's education, well-being, health and safety and/or coordination of services. I am also aware that this information may be transmitted electronically via a password secured system during times of travel and competition. I hereby release Killington Mountain School, its affiliates, faculty members, nurses, athletic trainers, administrators, coaches and employees from any liability, damages and expenses arising in connection with the receipt, use disclosure or discussion of my child's health information and records.

Signature of parent or guardian _____ Date _____

Authorization and Consent to Medical Treatment

Understanding that my child may need emergency or non-emergency treatment while attending Killington Mountain School, I authorize the school, through its nurses, trainers, coaches, administrators and faculty to administer such first aid or other minor medical treatment, including over-the-counter medications, which shall be deemed best under the circumstances, and I consent for my child to receive such treatment. I understand the school will attempt to notify me, or my spouse, in the event of an emergency requiring immediate medical care, and if the school is unable to notify me, I consent to have my child treated by a duly qualified physician at the nearest emergency facility. I will not hold Killington Mountain School financially responsible for the emergency care and/or transportation of my child. I acknowledge that it I my responsibility to keep my child's health records current. I also understand the obligation to provide medical insurance for my child rests with me as a parent or guardian.

Signature of parent or guardian _____ Date_____

Over the Counter Medication Authorization

Student name

Medications that are stocked in the school office are listed below. Your child may demonstrate certain signs and symptoms that could benefit from these medications. Over-the-counter medications will be administered according to the manufacturer indications and age/weight appropriate directions as written on the label.

Medications stocked in the office

Ibuprofen/Advil//Motri

- Acetaminophen/Tylenol
- Aleve
- Triple Antibiotic Ointment (Bacitracin, Neomycin, etc.)
- Benadryl
- Caladryl
- Hydrocortisone Cream
- Hydrogen Peroxide
- Imodium
- Maalox/Tums
- Pepcid
- Pepto Bismol
- Robitussin
- Sudafed
- Nyquil
- Dayquil/Dayquil Cough
- Throat lozenges/cough drops

❑ Yes, I give permission for my child to receive the above medications, if deemed necessary.
❑ My child may receive any of the above medications with the following exceptions:
❑ I request to be notified before any medication is administered.

Signature of parent or guardian **Date**

Prescription Medication Authorization

Prescription medication may be brought to school for administration only with a written consent from a parent. Medication to be administered must be in the original container labeled by the pharmacy or physician.

Name of medication	Dosage	Time to be given	Reason for medication	Special instructions

My child has permission to receive the above medication(s) as directed.

Signature of parent or guardian **Date**

Medical History

To be filled out by the physician.

Explain "yes" responses in space provided below.

	Yes	No		Yes	No		Yes	No
Measles			Asthma (note frequency below)			Back problems		
German measles			Shortness of breath			Tumor, cancer, cyst		
Mumps			Allergies (please list all below)			Jaundice		
Chicken Pox			Sleepwalking			Gallbladder trouble or gallstones		
Malaria			Insomnia			Hypoglycemia		
Amoebic Dysentery			Anxiety			Recurrent diarrhea		
Gum or tooth trouble			Depression			Hernia		
Sinusitis			Eating disorder			Recent gain or loss of weight		
Eye trouble			Pain/pressure in chest			Dizziness, fainting		
Ear, nose, throat trouble			Chronic cough			Weakness, paralysis		
Recent surgery			Palpitations (heart)			Diabetes		
Recurrent headaches			High or low blood pressure			Kidney disease		
Recurrent colds			Rheumatic fever or heart murmur			Other (please note below)		
Head injury with unconsciousness			Disease or injury of joints			***For Women Only***		
Tuberculosis			Frostbite			Irregular periods		
Seizures			Circulation problems			Severe cramps		
			Trick knee, shoulder, etc.			Excessive flow		

	Yes	No
Has the student's physical activity been restricted during the past five years? (Provide reasons and durations)		
Has the student received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?		
Is the student currently receiving counseling?		
Has the student had any illness or injury or been hospitalized other than already noted?		
Does the student currently or has the student in the past had any problems with substance abuse or chemical dependency?		
Has the student been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine check-ups)		
Has the student been immunized against tuberculosis with BCC vaccine?		
Do you have any concerns in regard to the student's health, family history or other matters which you would like to discuss now with a Killington Mountain School administrator?		

Please explain "yes" responses below

Medical History

To be completed by the physician.

Please review the student's history and complete this form. Please comment on all "yes" answers. This information is strictly for the use of the Health Service and will not be released without parent consent.

Student Name

Date of birth Date of last physical exam

Blood pressure Pulse Height Weight

Immunization Record

Vermont's immunization law requires vaccination of all children enrolled in school. You may attach a copy of shot record.

	Dates administered				
DTaP/DTP 5 doses					
IPV/OPV (polio) 4 doses					
Hepatitis B 3 doses					
MMR 2 doses					
Varicella 2 doses					
TDAP/Td 1 dose					
Meningococcal - Required only if living in a dorm					

Medical conditions

Explain "yes" answers in space provided below.

	Yes	No		Yes	No	*Musculoskeletal:*	Yes	No
Hearing			Genitourinary			Neck/back		
Vision			Gastrointestinal			Leg/ankle		
Head, ears, nose, throat			Metabolic/endocrine			Foot		
Respiratory			Skin			Knee		
Cardiovascular			Neuropsychiatric			Hip/thigh		
			Other			Shoulder/elbow/arm		
						Wrist/hand		

Please explain "yes" responses below

Signature of Physician:_____ Date: _____

Well Exam – Sports Participation Clearance Form

NOTE: How often a clearance form is needed to play sports is determined by your school. This clearance form is the only sports Participation Clearance Form supported by the Vermont Principals' Association , the Vermont Departments of Health and Education, and the Vermont Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. The American Academy of Pediatrics Council on Sports Medicine and Fitness developed the research based screening activities done during a Well Exam to determine sports readiness.

Student's Name _____

Age _____ Date of Birth _____ Grade _____

This athlete is:

- □ Cleared without restriction
- □ Cleared, **with restrictions**

_____

_____

- □ Not cleared for:
  - □ All sports
  - □ Certain sports _____

Reason: _____

_____

Relevant Medical Information for Coaches and Athletic Department:

Allergies _____ EpiPen Necessary Yes No

Asthma Yes No Emergency Medications _____

Diabetes Yes No Emergency Medications _____

Seizure Disorder Yes No Emergency Medications _____

Well Exam using ICD-9-CM code:

99383 or 99393 99384 or 99394 99385 or 99395

5 – 11 years 12 – 17 years 18 – 39 years

NOTE: Clearance form is not valid unless one of these Well Exam codes is checked by Practitioner

Comments: _____

_____

_____

Name of Practitioner (print/type) _____ Practitioner Phone # _____

Signature of Practitioner _____ Date of Exam _____/_____/_____

Suggestion for Athletic Department: Please make copy for School Nurse's Office records