

March 2011

Dear Families,

Riverview's Health Care Center welcomes our new and returning students for the 2011-2012 school year. In preparation, you will find the paperwork that needs to be completed **prior** to enrollment in the summer and/or fall program. This must be done **annually** and, therefore, includes returning students. As required by the Commonwealth of Massachusetts, the Department of Early Education and Care, and the Department of Mental Health, it is **mandatory** that all the forms are returned to the Health Care Center before your child begins the summer or fall program (i.e., May 1st for the summer program and July 1st for the fall program.)

Prior to your son/daughter's arrival, it is essential that we have proper authorizations and completed forms in place. Only with your support can we be best prepared to manage any health care needs or emergencies that might arise. **The School will not accept students who are without appropriate medical insurance and/or updated documentation. Parents will have to remain with their child until the paperwork is complete.** Please mail or fax forms as they are completed. In addition, evidence of all required vaccinations must be documented on Form 5A.

Please feel free to contact the Health Care Center if you have any questions or concerns.

Sincerely,

Cate MacFarland, RN
Director of Health Care Services

Enclosures

RIVERVIEW SCHOOL

Medical Forms Checklist

2011 - 2012

The following forms **must be completed every year.**
(Keep a copy of these forms for your files.)

- Form 1 Medical Release
(To enable HCC staff to seek medical attention, i.e., medical appointments, emergencies)
Medical Emergency Contact Information
Parent/Guardian's signature required
- Form 2 Medical Care Authorization
(Return with a copy of the front and back of insurance and/or prescription card)
Authorization to Dispense Prescription Medication
Parent/Guardian's signature required
- Form 3 PharMerica
MUST BE COMPLETED EVEN if you use another pharmaceutical provider
Parent/Guardian's signature required
- Form 4 Health Care Form for New or Returning Students
(Mandatory annual update)
- Form 5A Record of Immunizations
(Mandatory for new students. Updates as needed for returning students if received booster or vaccination)
Doctor's signature required
- Form 5B Health Care Providers Examination (Mandatory Annual Update)
Doctor's signature required
- Form 5C Approval for Activities
(Permission form for school activities no restrictions/limitations due to health conditions)
Parent/Guardian signature required & Doctor's signature required
- Form 6 Dental Certificate
(Mandatory annual update)
Dentist's signature required
- Form 7 Authorization to Dispense Over-the-Counter Medication
Parent/Guardian's signature required & Doctor's signature required
- Form 8 Medication Order Form
Doctor's signature required
- Form 9 Doctor's Information Sheet
(To facilitate communication with physicians currently treating the student)

STUDENT NAME: _____ D.O.B.: _____

ADDRESS: _____ RELIGIOUS AFFILIATION _____
(Street) (Town) (State) (Zip)

HOME PHONE: _____ FAX (Home): _____

BUSINESS PHONE (F): _____ FAX (F): _____

BUSINESS PHONE (M): _____ FAX (M): _____

CELL PHONE (M): _____ CELL PHONE (F): _____

EMAIL (M): _____ EMAIL (F): _____

PARENT/GUARDIAN NAME: _____ PERSON RESPONSIBLE FOR PAYMENT: _____

INSURANCE COMPANY: _____ POLICY #: _____ GROUP #: _____

SUBSCRIBER: _____ ADDRESS (if different): _____

Please list the name(s) and number(s) for any person(s) you want to be notified in case of a medical emergency **other than** parent/guardian or licensed prescriber.

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

Please include a copy of insurance card and prescription card (both sides).

CONSENT TO OPERATE, ANESTHETICS AND OTHER SURGICAL AND MEDICAL TREATMENT AND SERVICES

Although every effort will be made to contact the listed parent/guardian, it must be acknowledged that there may be occasions when my child/ward will require operative and/or related medical treatment on an emergency basis or without there being time for me to be contacted or consulted. I hereby consent to such operative or other medical treatment reasonably necessary in the opinion of the attending physician or physicians, for the well-being of my child/ward. Further, I authorize the attending physician or physicians, or emergency care staff, to carry out the necessary treatment.

I authorize the personnel in charge of my child/ward at the Riverview School, Inc. to communicate this consent and release form on my behalf to such hospitals, medical doctors or emergency care staff as may be required. A photocopy of the Release shall be considered valid for this purpose.

I hereby waive and release any claim I have individually or on behalf of my child/ward against the Riverview School, Inc., its agents, servants and employees in connection with any liability arising out of the medical treatment rendered.

Please list **ALL MEDICAL DIAGNOSES:** _____

Does your child have any drug, food or environmental allergies? Yes No (if yes, specify): _____

Parent/Guardian Signature: _____ Date: _____

**F O R M 2 RIVERVIEW SCHOOL Medical Care Authorization
2011 - 2012**

Student's Name: _____ D.O.B.: _____ Date: _____

In order to better serve your son/daughter, please check off below how you would like the HCC to proceed when your child requires non-emergency medical care in order to comply with your insurance plan's guidelines.

Please note: The HCC does call parents AFTER any non-routine visits to the Doctor.

_____ Please call me BEFORE my child is taken to the Doctor so I can arrange for "pre-approval."

_____ My child may go to the Doctor without "pre-approval."

_____ I will pick up my child and take him/her to his/her physician at home if needed.

_____ My child is authorized to see the following physician in the school's area:

Physician's Name: _____

Phone Number: _____

Address: _____

I understand that I am legally responsible for any balance that is not covered by insurance.

Parent/Guardian Signature

Date

The parent or guardian must make all insurance arrangements and pre-approvals. If you have any questions regarding the above, please contact the Health Care Center staff.

Please provide a copy of your child's insurance and prescription cards (both sides) to be kept on file in the Health Care Center.

**Authorization to Dispense Prescription Medication
2010 - 2011**

By my signature below, I approve to have the school nurse or school personnel designated by the school nurse to administer the prescription medication and health care services. The completed prescription medication administration record(s) shall be filed in the student's cumulative health record.

Parent/Guardian Signature: _____

By my signature below, I acknowledge that a prescription medication administration plan must be established with the school nurse in collaboration with the parent or guardian. Whenever possible, this plan shall involve the student who understands the issues of medication administration in the decision-making process and his/her preferences respected to the maximum extent possible. If appropriate, the medication administration plan will be referenced in any other health or educational plan developed pursuant to Massachusetts (i.e., 766) or Federal (i.e., IDEA or Rehabilitation Acts of 1973) laws.

F O R M 4

**RIVERVIEW SCHOOL
Health Care Form for New Students
2011 - 2012**

Student Name: _____ D.O.B.: _____

MEDICAL HISTORY

Current Medical Diagnosis: _____

Past medical diagnoses: _____

Past medical and surgical history (operations, hospitalizations, serious illnesses). Include dates: _____

Does your child have a history of or a current psychiatric/psychological diagnosis? Please explain:

Is your child prone to any illnesses? (e.g. frequent ear infections, ingrown toe nail problems, etc.): _____

Known drug allergies: _____

Known food or environmental allergies: _____

Does your child receive allergy injections? Yes _____ No _____ If yes, how often? _____

SEIZURE DISORDERS

Does your child have a seizure disorder? _____

Does he/she have any warning signs and/or "aura"? _____

Describe type and duration of seizures, and date of last known seizure: _____

Any after effects? _____

On average, how many seizures per week? _____ per day? _____ per month? _____

Student Name _____

DIET & NUTRITIONIs your child on a medically restricted diet? YES NO

If yes, please specify why and provide a detailed list of what your child can and cannot eat. Also, please provide information about foods your child does not eat. (Use a separate sheet of paper if necessary.) _____

Has your child had problems with eating disorders, e.g., bingeing, purging, refusing to eat? _____

Any other health care concerns that we should be aware of at this time (e.g., unable to participate in physical education classes, etc.)? _____

Describe any treatment strategies or anecdotal information that would assist our staff in meeting your child's medical/health needs: _____

PERSONAL HYGIENE

Please explain if your child will need assistance with any of the following.

Skin _____ Hair _____

Eyes _____ Glasses _____

Teeth _____ Braces _____

Ears _____ Hearing Aids _____

Dressing _____

Showering _____ Shaving _____

Bladder Control _____ Bowel Control _____

Menstrual Cycle _____

At what age did menses begin? _____ If not, is your child aware of body changes? _____

Any other hygiene concerns? _____

Is your child afraid of loud noises? YES NO storms? YES NO dark? YES NO

Does your child have difficulty falling asleep? _____

Any problems with sleepwalking? _____

Does your child have difficulty swallowing pills? YES NO If yes, please provide liquid medications.Does your child require lab work? YES NO If yes, a physician's written order is required.

Specify: _____

Is your child afraid of doctors? YES NO Needles? YES NO

How does your child react when ill? _____

Will your child be able to let staff know when they are not feeling well? YES NO

FORM 5A / Riverview School

Fax: 508-833-7004

Certificate of Immunization / 2011-2012

Name: _____ Date of Birth: / / Sex: M F

(If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.))

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, Hep B-Hib, DTaP-HepB-IPV, HepA-HepB)	1		Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1	
	2			2	
	3			3	
	4		Measles, Mumps, Rubella (MMR, MMRV)	1	
		2			
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	1		Varicella (Var, MMRV)	1	
	2			2	
	3		Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	4			2	
	5			1	
	6			2	
	7			3	
		4			
Haemophilus Influenzae type b (e.g., Hib, HepB-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib)	1		Influenza Inactivated (Intramuscular) or Live (Intranasal)	5	
	2			6	
	3			1	
	4			2	
		3			
		4			
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib)	1		Hepatitis A HepA, HepA-HepB)	1	
	2			2	
	3		Human Papillomavirus (HPV)	1	
	4			2	
	5			3	
		Other			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella *	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check this box if this person has a physician-certified reliable history of chicken pox. Date: _____ Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.	
Doctor or nurse's name (please print): _____	Date: / /
Signature: _____	
Facility Name: _____	

RIVERVIEW SCHOOL FORM 5B

Fax: 508-833-7004

Health Care Provider's Examination 2011-2012

Date of Examination _____

Name _____ Date of Birth _____ Male Female

Medical History _____

Pertinent Family History _____

Current Health Issues

Yes No
 Allergies (please list) Medications _____ Food _____ Other _____
 Asthma Asthma Action Plan Yes No (If yes, please attach)
 Diabetes Type I Type II
 Seizure Disorder _____
 Other (please specify) _____

Current Medications

(If relevant to the student's health and safety.) A separate medication order is needed to medications.

Physical Examination

Height _____ (_____ %) Weight _____ (_____ %) BMI _____ (_____ %) BP _____

(Check = Normal. If abnormal, please describe)

General _____ Lungs _____ Extremities _____ Skin _____
 Heart _____ Neurologic _____ HEENT _____ Abdomen _____
 Dental/Oral _____ Genitalia _____ Other _____

Screening

Vision Right Eye Pass Fail Hearing Right Ear Pass Fail Postural Screening Pass Fail
Left Eye Pass Fail Left Ear Pass Fail (Scoliosis/Kyphosis/Lordosis)
Stereopsis Pass Fail

Laboratory Results

Lead Date _____ Other _____

The entire examination was normal

Targeted TB Skin Testing

Med-to-High Risk (exposure to TB; born, lived, traveled to TB endemic countries; medical risk factors)
Date of PPD _____ Results _____ mm Referred to evaluation to _____
 Low Risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

Vision Hearing Speech/Language Fine/Gross Motor Skills Emotional/Social Behavior Other
Comments/recommendations _____

Yes No This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions _____

Yes No Immunizations are complete. If not, give reason. Please attach Massachusetts Immunization Information System Certificate or other complete immunization record. _____

Signature of Examiner _____ Print name of Examiner _____ Circle: MD, DO, NP, PA _____ Date _____

Address _____ City _____ State _____ Zip Code _____ Telephone _____

Please attach additional information as needed for the health and safety of the student.

F O R M 5C

**RIVERVIEW SCHOOL
Health Care Permission Form
2011 - 2012**

Student Name: _____ D.O.B.: _____

- This student may participate fully in school activities. He/She has no restrictions/limitations due to health conditions.

- This student may participate in all competitive/intramural athletic/activities without restriction.

- This student may not participate in the following activities listed below. Please specify (e.g., all amusement park rides, physical education, competitive sports and swimming activities.)

Parent/Guardian signature

Date

Physician's signature

Date

FORM 6

**RIVERVIEW SCHOOL
Dental Certificate
2011 - 2012**

A report of an annual examination is required for each student by the
Massachusetts Department of Early Education and Care.

This statement must be signed by the family dentist and then returned to Riverview School. Efforts should be made to have all dental work done that is necessary with:

1. The mouth as clean as possible with special attention to food debris and tartar.
2. All cavities adequately treated.
3. Attention given to all pits and fissures in deciduous and permanent teeth.
4. All dental infection eliminated.

The final opinion concerning any mouth conditions rests with the family dentist.

TO BE COMPLETED AND SIGNED BY FAMILY DENTIST:	
This is to certify that _____ <small>(student name)</small>	
is receiving dental care from this office.	<input type="checkbox"/> Yes <input type="checkbox"/> No
has had all work done that is necessary at this time.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist's signature: _____	
Dentist's name, address and phone number (please print): _____ _____	
Date: _____	

******A REPORT OF AN EXAMINATION IS NECESSARY EACH YEAR******

FORM 7

**RIVERVIEW SCHOOL
Authorization to Dispense Over-the-Counter Medication
2011 - 2012**

The following is a list of over-the-counter (non-prescription) medications that have been approved by a physician for school use. These may be given at the discretion of the nursing staff, as needed. No child will receive a medication if contraindicated (i.e. past allergic reaction or existing medical condition prohibits use).

If you DO NOT WANT your child to receive a medication listed below, please CIRCLE IT.

- | | |
|--------------------------------------|---|
| Robitussin | Sunscreen (various SPF) |
| Robitussin DM | Bacitracin, Neosporin, Triple Antibiotic Ointment |
| Phenylephrine/ Pseudoephedrine | Tolnaftate, Clortrimazole antifungal cream/powder |
| Ibuprofen tablets/liquid | Medicated lip balm |
| Tylenol/acetaminophen tablets/liquid | Ear wax removal drops (Debrox or Colace drops) |
| Benadryl tablets/liquid/spray | Maalox, Mylanta, Tums, Roloids |
| Refresh eye drops or equivalent | Imodium tablets |
| Hydrocortisone 1% cream or ointment | Milk of Magnesia |
| Insect Repellent | First Aid spray |
| Motion sickness/antemetic (Bonine) | Anbesol |
| Aloe Vera gel or lotion | |

PLEASE NOTE: If your child takes **ANY** other over-the-counter product including dietary supplements, which are not listed above, please add them in the space provided below. Without the **physician's signature**, we will not administer any over-the-counter or dietary supplements.

Other: _____

- **If your child requires a specific over-the-counter medication (e.g., Tylenol Cold, Sudafed), please provide the medication to HCC and indicate above.**
- We may use the generic equivalent of the medications listed above. Please indicate above if your child cannot receive the generic form of these medications.
- This form must be signed by the parent/guardian and by the student's Primary Care Physician. It will become part of your child's records.
- I understand that my child may receive an over-the-counter medication, if necessary, at the discretion of the nursing staff.
-

Primary Care Physician signature: _____ Date: _____

Physician's name and address (please print): _____

Name of Student: _____ Date of Birth: _____

Parent/Guardian signature: _____ Date: _____

FORM 8

RIVERVIEW SCHOOL
Medication Order (Not a prescription)
2011 - 2012
Fax: 508-833-7004

Attention Licensed Prescriber: PharMerica is Riverview School's pharmacy. The pharmacy will contact the prescriber on a monthly basis for refills of controlled medications. All other medications will require prescriptions for the school year.

Attention School Year Parents: In preparing for your child's arrival in September, **please bring AT LEAST TWO (2)** weeks of medications including topicals, ear drops, eye drops, etc., as well as written prescriptions for these medications

Attention Summer Program Parents: Please provide medications for the 5-week program.

Name of Student: _____ Date of Birth: _____

Address: _____

Name of Licensed Prescriber: _____ Office Telephone #: _____ Fax #: _____

Prescriber Address: _____

Date of Order	Medication	Dose	Specific Directions	Route	Time	Frequency

Diagnosis: _____ Other medical condition(s): _____

Signature of Licensed Prescriber: _____ Date: _____

F O R M 9

**RIVERVIEW SCHOOL
Doctor's Information Sheet
2011 – 2012**

Please include any medical doctors on this sheet who prescribe medications and/or provide care for your child.

Student: _____ Date of Birth: _____

Doctor's Name: _____ Specialty: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____ Email: _____

Doctor's Name: _____ Specialty: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____ Email: _____

Doctor's Name: _____ Specialty: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____ Email: _____

Doctor's Name: _____ Specialty: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____ Email: _____

Doctor's Name: _____ Specialty: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____ Email: _____