

March 2010

Dear Families,

Riverview's Health Care Center welcomes our new and returning students for the 2010-2011 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,

Sharron Rinaldi, RN  
Acting Director of Health Care Services

Enclosures

To ensure that your child meets the  
Massachusetts requirements for an  
overnight visit at Riverview:

Please fax (508-833-7004)

or

mail overnight

to 551 Route 6A  
East Sandwich, MA 02537

all health care forms two weeks  
prior to your visit.

Thank you.

# RIVERVIEW SCHOOL

## Medical Forms Checklist – Visiting Student 2010 - 2011

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

- |                          |         |   |
|--------------------------|---------|---|
| <input type="checkbox"/> | Form 1  | Medical Release<br>(To enable HCC staff to seek medical attention, i.e., medical appointments, emergencies)<br>Medical Emergency Contact Information<br><u>Parent/Guardian's signature required</u>   |
| <input type="checkbox"/> | Form 2  | Medical Care Authorization<br>(Return with a copy of the front and back of insurance and/or prescription card)<br><u>Parent/Guardian's signature required</u><br>Authorization to Dispense Prescription Medication<br><u>Parent/Guardian's signature required</u> |
| <input type="checkbox"/> | Form 3  | Not Applicable.   |
| <input type="checkbox"/> | Form 4  | Health Care Form for New (2pages) or Returning Students (1 page)<br>( <u>Mandatory annual update</u> )  |
| <input type="checkbox"/> | Form 5A | Record of Immunizations<br>(Mandatory for new students-update as needed for returning students if received booster or vaccination since the form was originally completed)<br><u>Doctor's signature required</u>  |
| <input type="checkbox"/> | Form 5B | Health Care Providers Examination (Mandatory Annual Update)<br><u>Doctor's signature required</u>   |
| <input type="checkbox"/> | Form 5C | Not Applicable  |
| <input type="checkbox"/> | Form 6  | Not Applicable  |
| <input type="checkbox"/> | Form 7  | Authorization to Dispense Over-the-Counter Medication<br><u>Parent/Guardian's signature required</u> & <u>Doctor's signature required</u>   |
| <input type="checkbox"/> | Form 8  | Medication Order Form<br><u>Doctor's signature required</u>   |
| <input type="checkbox"/> | Form 9  | Not Applicable  |

**FORM 1 RIVERVIEW SCHOOL Medical Release 2010-2011**

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  
2010 - 2011**

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  
2010 - 2011**

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 & NUTRITION**Is 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 / 2010-2011

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

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"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

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

**FORM 5B**

**RIVERVIEW SCHOOL**

Fax: 508-833-7004

**Health Care Provider's Examination  
2010-2011**

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  
2010 - 2011**

Student Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

- This student may participate fully in school activities. He/She has no restrictions/limitations due to health conditions, e.g., cardiac, seizure.
  
- This student may not participate in the following activities listed below. Please specify (e.g., all amusement park rides, physical education and competitive sports):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

**FORM 7**

**RIVERVIEW SCHOOL  
Authorization to Dispense Over-the-Counter Medication  
2010 - 2011**

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 |
| Sudafed PE tablets/liquid            | 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)**  
**2010 - 2011**  
**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: \_\_\_\_\_