

RIVERVIEW SCHOOL

Medical Forms Checklist

2009 - 2010

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)
Parent/Guardian's signature required
- Form 2A Medical Care Authorization
(Return with a copy of the front and back of insurance and/or prescription card)
Parent/Guardian's signature required
- Form 2B Authorization to Dispense Prescription Medication
(Authorization as well as emergency contact information)
Parent/Guardian's signature required (2 places)
- Form 3 PharMerica
(To be completed and mailed to HCC along with a copy of the front and back of insurance and/or prescription card)
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 annual update)
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)

FORM 1

**RIVERVIEW SCHOOL
Medical Release
2009 – 2010**

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 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 A

**RIVERVIEW SCHOOL
Medical Care Authorization
2009 - 2010**

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

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.

F O R M 2 B

**RIVERVIEW SCHOOL
Authorization to Dispense Prescription Medication
2009 - 2010**

Student's Name: _____ Today's Date: _____

Student's Date of Birth: _____

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.

Parent/Guardian Signature: _____

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: _____

Phone: _____

Address: _____

Name: _____ Relationship: _____

Phone: _____

Address: _____

F O R M 4

**RIVERVIEW SCHOOL
Health Care Form for Returning Students
2009 - 2010**

Student Name _____ D.O.B. _____

Please update us on any changes in your child's medical status since the original Health Care forms were filled out last year. Changes in address and/or insurance may be noted on Form 1 Medical Release.

Diagnoses? _____

Surgical procedures done over the summer? _____

Medications (please note time and dosage)?

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Newly diagnosed allergies (environmental, food, and/or drug)? _____

Change in diet or nutritional status? _____

New therapies (physical, occupational, counseling)? _____

Comments and/or any new treatment strategies or anecdotal information on the student that would assist the staff in meeting the student's medical/health needs: _____

FORM 5A / Riverview School

Fax: 508-833-7004

Certificate of Immunization / 2009-2010

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: _____	

F O R M 5 B

RIVERVIEW SCHOOL

Fax: 508-833-7004

**Health Care Provider's Examination
2009-2010**

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
2009 - 2010**

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 6

**RIVERVIEW SCHOOL
Dental Certificate
2009 - 2010**

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 style="text-align: center;">(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
2009 - 2010**

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 |
| Kaopectate | Ear wax removal drops (Debrox or Colace drops) |
| Tylenol/acetaminophen tablets/liquid | Benadryl tablets/liquid/spray |
| Refresh eye drops or equivalent | Maalox, Mylanta, Tums, Rolaids |
| Hydrocortisone 1% cream or ointment | Imodium tablets |
| Insect Repellent | Milk of Magnesia |
| Motion sickness/antemetic (Bonine) | First Aid spray |
| Aloe Vera gel or lotion | Anbesol |

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.

Name of Student: _____ Date of Birth: _____
Parent/Guardian signature: _____ Date: _____
Primary Care Physician signature: _____ Date: _____
Physician's name and address (please print): _____

FORM 8

**RIVERVIEW SCHOOL
Medication Order
2009 - 2010
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
2009 – 2010**

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: _____