

NEW STUDENT PHYSICAL AND IMMUNIZATION REQUIREMENTS

Physical Examination Report - Required for ALL new students

This physical form is to be completed by the physician performing the physical exam. The laboratory tests are optional. A physical is required for all new students. The state also mandates required vision, hearing and scoliosis screenings for all new students. It is optional for parents to have their physician perform vision, hearing and scoliosis screening on their child. If the vision, hearing and scoliosis screenings are not completed, the St. Stephen's medical staff will administer the screenings at a charge of \$25 per test.

Immunization Record

The State of Texas Health Department requires St. Stephen's to have a complete and current immunization record on each student. You will be notified by the Health Center if your current file is not complete and up to date. Any new required immunizations received by your child since their last physical must be listed on a physician report and should include the month/day/year in which it was given. Immunization records with only the year or series are not acceptable. Please be sure that your child's measles, tetanus, polio and hepatitis immunizations are up to date, including the booster. If your child is a boarding student or in Middle School, the meningococcal vaccine is mandatory. If you are a middle school or boarding student and have not had these vaccinations/tests, you must either receive them before you leave your home country or receive them from the St. Stephen's school physician at an extra charge within 30 days of arrival on campus.

In order for your child to attend sports camps or register for the first day of classes, the Health Center must have all medical forms on file. If you have any questions, please contact the Health Center at (512) 327-1213, extension 231.

MANDATORY IMMUNIZATIONS-any missing immunizations are due by April 1, 2011

The following vaccinations are required:

1. DTP (Diphtheria, Tetanus, Pertussis (Whooping Cough))

Five doses of diphtheria-tetanus-pertussis vaccine; one dose must have been received on or after the 4th birthday. However, 4 doses meet the requirement if the 4th dose was received on or after the 4th birthday. For students aged 7 years and older, 3 doses meet the requirement if one dose was received on or after the 4th birthday.

2. Tdap (Tetanus/Diphtheria/Pertussis)

For 7th grade: 1 dose of Tdap is required if at least 5 years have passed since the last dose of tetanus-diphtheria-containing vaccine.

For 8th – 12th grade: 1 dose of Tdap is required when 10 years have passed since the last dose of tetanus-diphtheria-containing vaccine. Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.

3. Polio

4 doses of polio vaccine one of which must have been received on or after the 4th birthday; however, 3 doses meet the requirements if the 3rd dose was received on or after the 4th birthday.

4. Measles, Mumps, and Rubella (MMR)

The first dose of MMR must be received on or after the 1st birthday. For 2nd – 12th grade the requirement is 2 doses of a measles-containing vaccine, and one dose each of rubella and mumps vaccine.

5. Hepatitis B

For students aged 11-15 years, 2 doses meet the requirement if adult hepatitis B vaccine (Recombivax) was received. Dosage and type of vaccine must be clearly documented. (Two 10 mcg/1.0 ml of Recombivax).

6. Chicken Pox (Varicella)

The first dose of varicella must be received on or after the first birthday. 2 doses are required for K, 1st, 7th, and 8th grade. 1 dose is required for all other grade levels. For any student who received the first dose on or after 13 years of age, 2 doses are required.

7. Meningococcal / Meningitis –

REQUIRED FOR ALL BOARDING STUDENTS & ALL STUDENTS GRADES 6-8 The State now requires students 8th grade and below to have one dose of this vaccine. Boarders must have the vaccine. If the parent wishes, the school will arrange this important immunization for any boarder if they have not received this vaccine upon arrival to campus. However, there is a charge for this vaccination.

8. Hepatitis A

The first dose of hepatitis A must be received on or after the first birthday.

9. Tuberculosis – REQUIRED FOR INTERNATIONAL STUDENTS ONLY

In addition to required vaccinations, you must have a tuberculosis (TB) skin test using the Intradermal Mantoux Method – not a multiple puncture test – within ninety (90) days prior to the opening of the school, unless you have had a negative test result within the last year. If you have had a positive skin test or have received BCG within the last five years, a copy of the CXR report (xray) is required.

NEW STUDENT PHYSICAL EXAMINATION REPORT

All Sections Must be Completed by Physician within the 2011 calendar year

Date of Exam _____

Student's Name _____ Birthdate _____ Gender ___ M ___ F

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Vision (R) 20/_____ (L) 20/_____ with correction _____ without correction _____

	Normal	Abnormal	Not Examined	Comments
1. Eyes				
2. Ears, Nose, Throat				
3. Neck (soft tissue)				
4. Mouth and Teeth				
5. Cardiovascular				
6. Chest and Lungs				
7. Abdomen				
8. Genitalia-Hernia				
9. Sexual Maturity				
10. Skin & Lymphatics				
11. Neck				
12. Spine (Scoliosis Screening)				
13. Shoulders				
14. Arms and Hands				
15. Hips				
16. Thighs				
17. Knees				
18. Ankles				
19. Feet				
20. Neurological				

Based on this history, vision screening, and physical exam, the following abnormalities were found and may need treatment.

1. _____ 2. _____ 3. _____

MANDATORY to be completed by a physician. Based on this history and physical exam, is there any reason why this student should NOT participate in sports?

- Yes If yes, explain on back.
 No

IMMUNIZATION UPDATES: Names and dates of any new immunization boosters

Immunization and Date _____ / ____ / ____

Immunization and Date _____ / ____ / ____

PHYSICIAN'S VERIFICATION OF MEASLES/MUMPS ILLNESS

- Measles on or about _____
 Mumps on or about _____
 Varicella (chickenpox) on or about _____

OPTIONAL LABORATORY TESTS

1. Hemoglobin/Hematocrit _____ / ____
 2. Urinalysis _____
 3. Other: _____
 4. No lab done _____

Hz	250	500	1000	2000	4000	6000	This test must be performed at 25 decibels.
R							
L							

Physician's Signature _____ Date _____

Physician's Name _____ Office Telephone () _____

Physician's Address _____
 Street City State Zip+4

MEDICAL AUTHORIZATION FORM

Student Name _____ Date of Birth _____

Social Security Number _____ - _____ - _____

I/We understand that it is the policy of St. Stephen's Episcopal School (the "School") to make reasonable efforts to contact me/us in the event of an emergency involving the mental or physical health of my/our child. However, I/we also understand that circumstances can arise that make it impracticable for the School, to contact me/us in an emergency. Accordingly, School representatives are hereby authorized to take such actions as they deem necessary to protect the health and welfare of my/our child, including but not limited to, securing and consenting to emergency services, anesthetics, medical and psychiatric services (general and specialized) and hospital and psychiatric hospital admission. I/we also authorize school representatives to secure and consent to the administration of immunizations to my/our child in the event my/our child's immunization record is found to be deficient under standards promulgated by the Texas Department of Health. I/We also grant permission to the School's physicians, nursing staff, athletic trainers and authorized representatives to assess and render aid and treatment, and to administer daily health care to my/our child as deemed reasonable and necessary by them. I/We understand that the cost of such services will be borne by me/us and I/we agree to pay for all such services provided to my/our child promptly upon receipt of the statement therefor, and I/we further agree to indemnify the School, its employees, agents and representatives, and hold it and them harmless from any claims, charges or assessments arising out of the School's providing and/or procuring health care and/or treatment for my/our child.

In the event my/our child receives medical treatment, I/we authorize my/our child's physician(s) and any other person or entity in possession of any medical records pertaining to my/our child to release such medical records to the School. I/We understand that this medical authorization form is in effect and valid for so long as my/our child is enrolled at St. Stephen's Episcopal School.

Parent Signature _____	Date _____
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Father's Name _____ Social Security Number _____ - _____ - _____
Address _____ City _____ State _____ Zip code _____
Home phone (____) _____ Work phone (____) _____ Fax (____) _____
Car phone (____) _____ Pager (____) _____
Email _____

Mother's Name _____ Social Security Number _____ - _____ - _____
Address _____ City _____ State _____ Zip code _____
Home phone (____) _____ Work phone (____) _____ Fax (____) _____
Car phone (____) _____ Pager (____) _____
Email _____

If the persons listed above are not available in the event of an emergency, please contact:

Name _____ Relationship _____
Address _____ City _____ State _____ Zip code _____
Home phone (____) _____ Work phone (____) _____ Fax (____) _____
Car phone (____) _____ Pager (____) _____
Email _____

Date of Student's Last Diphtheria/Tetanus Booster _____

Please list any allergies _____

MEDICAL/HEALTH INSURANCE INFORMATION

St. Stephen's does not provide insurance for students. **Parents are required to have medical health insurance for their child.** Please complete the following:

Name of Insurance Company _____ Effective Date of Policy _____
Address _____ Phone (____) _____
Policy Number _____ Group Number _____
Name of Policy Holder _____ DOB _____ SS# _____

Students will not be allowed to register for classes or participate in athletics until this form is submitted.*See attached Rider. DUE DATE April 1, 2011

Patient Information
GROUP IMMUNIZATION
INFLUENZA (FLU) VACCINE for 2011-2012

Flu

Influenza (flu) is a respiratory disease caused by influenza virus infection. The types of strains of influenza virus may change from year to year, or even within the same year. People who get flu may have chills, fever, headache, dry cough and muscle aches and may be sick for several days to a week or more. Most people recover completely. However, for some people, flu may be especially severe, and pneumonia or other complications, including death, may develop.

Flu Vaccine

The regular flu vaccine contains killed influenza virus of the types selected by the U.S. Public Health Service and the Center for Biologics Evaluation & Research of the Food and Drug Administration. The types or strains of virus included are those which have most recently been causing influenza. The vaccine will not give you flu because it is a killed virus vaccine.

Risks and Possible Side Effects

Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at the injection site, or possibly fever, chills, headache or muscle aches. These effects usually last 24 to 48 hours. Most people who receive the vaccine either have no or only mild reactions. There is a possibility, as with any vaccine administration that an allergic or other serious reaction, or even death, could occur. Moreover, untoward medical events completely unrelated to vaccine administration may occur coincidentally in the aftermath period following vaccination.

Unlike the 1976 swine influenza vaccine, flu vaccines used subsequently have not been clearly associated with an increased frequency of Cullain-Barr Syndrome, which is associated with paralysis.

Special Notice

Check with a physician if vaccination is being considered for:

1. Children under 3 years of age;
2. Pregnant Women;
3. People allergic to eggs, chicken, or chicken feathers;
4. People sensitive to thimerosal;
5. People who have an allergic neurologic disorder;
6. People who have received another type of vaccine during the past 14 days;
7. People with a fever, acute respiratory or other active infections or illnesses.

If you have questions, please ask now or check with a physician or your health department before receiving the vaccine.

If you experience any significant reactions, see your physician.

I have read the above information about influenza and the influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to the person named below for whom I am authorized to sign.

I understand I will be charged a fee of \$25 for this vaccine. I further understand that I must pay this charge even if I later decide to waive the flu shot, to cover the school's cost for ordering the vaccine at my request.

Information – Person to Receive Vaccine				For Clinic Use	
Name				Name of Clinic	
Birthdate		Age		Date of Vaccine	
Address – Street		City	State	Manufacturer or Loc.	
Zip		Date		Site of Injection	
X Signature (Person receiving vaccine or Parent or Guardian)				Chronic Disease (circle one) Yes or No	

Boarding Student Medication Form

NON-PRESCRIPTION MEDICATION: Students may come to the Health Center for any Over the Counter (OTC) medication. OTC medications may not be in the students room without a signed parental permission indemnity form included in this packet.

PRESCRIPTION MEDICATION: All medications must be: (1) in their original containers; (2) be properly labeled from the pharmacy; (3) contain current dosage information; and (4) with this medication form. We are required to dispense your child's prescription medication exactly as your Doctor ordered. This form must be completed by the prescribing physician when other than Dr. Kerry Rhodes or Dr. Doug Elenz.

- **One form must be completed for each medication. Multiple medications cannot be listed on one consent form.**
- **Parents may complete the form for non-prescription medications and prescription medications that are given 10 days or less.**
- **The child's health care provider MUST complete the form for long-term medications or when dosage directions state "consult a physician." Dosage administration of insulin requires the health care provider complete the form.**

Child's first & last name _____ Date of birth _____

Name of medication (including strength) _____

Amount/dosage to be given: _____ Route of Administration _____

Frequency to be administered: _____ or Identify the symptoms that will necessitate administration of medication: (signs & symptoms must be observed when possible / measurable parameters):

Possible side effects: _____ Any known allergies: _____

What action should the health care provider take if side effects are noted:

Contact parent Contact prescriber at phone number provided below or Other (describe):

Additional special instructions: (include concerns related to possible interactions with other medications the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies, or an pre-existing conditions. Also describe situations when medication should not be administered:

Reason the child is taking the medication: _____

Date consent form completed: _____ Date to be discontinued or length of time in days to be given: _____

Prescriber's name (please print): _____ Prescriber's Phone Number: _____

Licensed authorized prescriber's signature: _____
(Required for Long-term medication or when dosage directions state "consult a physician.")

Parent signature: _____

Inhaler Permission: My child _____, has my permission to carry his/her asthma inhaler(s) and to use as prescribed by their physician. I understand that my child is responsible for the proper use of his/her inhaler medication(s) and that their use will not be monitored by the St. Stephen's medical staff.

Due April 1, 2011

Boarding Student Medication Permission Indemnity and Release Form

(Allows students to keep Over the Counter medications and certain prescription medications in their dormitory room)

To be completed by Parent/Guardian

My child, _____, has my permission to be responsible for taking his/her medications prescribed or approved for them by the St. Stephen's Episcopal School ("School") physician, Dr. Kerry Rhodes. I authorize the School nurses to dispense the labeled, original pharmacy bottle to my child with instructions on how to take this medication. My child will be given permission to keep these medications in their dorm room in the original, properly labeled container for use as prescribed. It is my understanding that this permission will not be granted for any controlled or psychotropic medications. My child must go to the Health Center to receive this type of medication. I also understand that the School may, for any reason, resume dispensing any medication directly to my child should, in the sole discretion of the School, the School deem this advisable.

I understand that by authorizing the foregoing self-medication procedure for my child I am allowing my child to assume full responsibility for appropriately storing, maintaining and self-administering the medications, and hereby Release, indemnify and hold the School (together with its agents and employees, including without limitation, its health staff and the School physician, Dr. Kerry Rhodes) harmless from any and all liability for any loss, damages or claims, incurred or suffered by me or my child which might arise from or in any way relate to my child participating in the foregoing self-medication program.

This permission form is in effect and valid for so long as my child is enrolled as a boarding student at St. Stephen's Episcopal School, or until revoked in writing delivered to the School's Head Nurse.

Student's Name _____ Date of Birth _____
Please Print

Parent Signature _____ Date _____

Parent Name (Printed) _____

Due Date April 1, 2011