St. Margaret's School

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Greetings!

We are excited to have your child join us at St. Margaret's School and want to do all we can to ensure your arrival to campus goes smoothly. The following outlines the information and medical documentation our Health Center **REQUIRES** you to provide.

Please complete the following forms and mail **ALL** information to St. Margaret's School, Attn: Brittany Bumgarner, RN, PO Box 158, Tappahannock, VA 22560 or scan and email to bbumgarner@smsapps.org by **August 1**:

1. **Part I: Student Health Information**—filled out completely, signed and dated three times at the bottom. On this form will be a required signature acknowledging the student must have insurance coverage for the duration of the time they are on campus and confirming you have read and understood the Student Health Polices as outline on the next page.
2. **Part II: Comprehensive Physical Examination**—completed and signed by your physician.
3. **Part III: Certification of Immunization**—also include a current copy of all immunizations translated into English if necessary.
   A. The following immunizations are required**:**
      - **Four Polio vaccines**
      - **Two Varicella vaccines/or history of Chickenpox documented**
      - **Five DTP vaccines—one within the last 10 years**
      - **Tdap booster**
      - **Hepatitis B vaccines—three doses**
      - **MMR—two doses or two doses of Measles and Mumps and at least one dose of Rubella**

   B. Meningeal/Meningitis Vaccine is **STRONGLY SUGGESTED** before arrival to campus. Please ask your physician to document this on Part II or Part III of these forms.
   C. Tetanus Vaccine must be within 10 years. The Tdap covers this and is mandatory.
4. **Influenza Vaccination Permission Form**—completed and signed by parent or guardian.
5. **TB Risk Assessment Questionnaire**— is required for **ALL STUDENTS**. International students must present documentation of a negative TB Screening/PPD Test or Chest X-ray.
6. Insurance verification is required for **ALL** students. **St. Margaret's School does not carry health care insurance for students. Health insurance coverage is required for all students while on campus**. Please provide a copy of the front and back of the insurance card. Internationals students, please use the ISM/ International insurance. If you use other insurance sources, please be sure they can be used in the United States and have a USA contact number. The ISM website is: https://secure.visit-aci.com/enrollment/home/ism.htm
7. All allergies must be documented.
8. Any medications brought to school **MUST** be in English. We encourage students to bring/buy their "over the counter" medications here, to be signed off by the nurses and kept in their rooms to use as needed.

Your child's health and well-being is our priority. Thank you for your trust in us as we care for your child while at St. Margaret's. We look forward to seeing you in the fall!

Sincerely,

St. Margaret's School Health Center

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STUDENT HEALTH POLICIES

1. **Health Forms:** Completed health forms and a copy of the front and back of all insurance cards must be on file in the Health Center by the beginning of the school year. Students may not participate in sports or off-campus activities without these forms on file. Insurance coverage is required for the duration of the school year. New insurance cards and policy changes during the school year need to be sent and communicated to the Health Center.

2. **Routine Health Care:** Students should have all routine medical, dental and ocular work completed before school opens or during vacations. An exception is continuing orthodontic care that will be arranged upon request from the parent.

3. **Absences for Medical Care:** Each night away from school for medical purposes must be approved by the nurse. *Note:* Any absence from class for medical reasons falls under the attendance policy and a doctor's note is required upon return.

4. **Permission for Medical Treatment:** The permission for medical treatment signed by the parent includes medical care and emergency care. Visits to specialists (including, but not limited to orthodontist, dermatologist, ophthalmologist, chiropractor, oral surgeon, podiatrist, etc.) must be specifically authorized by the parents. Parents will be billed directly by the physician. Transportation costs to health service providers will be billed to the student's account. There is no charge for consultation or services provided by the Health Center.

5. **Prescriptions:** Medications will be obtained from the designated pharmacy and will be billed directly to the parents.

6. **Possession of Medications:** All medications, including over-the-counter , must be kept in the Health Center with the exception of vitamins, herbal supplements, inhalers, nasal sprays, birth control pills that have been **initialed by the nurse.** Parents should mail any medication directly to the nurse, rather than their daughter.

7. **Health Insurance:** St. Margaret's School does not carry accident or health insurance on its students. All students are required to have their own insurance coverage for medical illness and for injuries that may occur during sports activities or at other times. This coverage must in place before the student arrives on campus and for the duration of the school year. Parents are responsible for acquiring referrals, if needed; otherwise the charge for services is the responsibility of the parents.

8. **Tanning Salons:** The school will not assume responsibility for the hazards involved in using the local tanning salons. **The tanning salon is off limits unless a student has written permission from her parents on file in the Health Center.** Under no circumstances does such an appointment take precedence over any school obligation.

St. Margaret's School

PART I: STUDENT HEALTH INFORMATION

State Law (Ref. Code of Virginia 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering school. The parent or guardian completes this page (Part I) of the form. The medical provider completes Part II and Part III State Required Immunizations.

Student's Name _____ Grade _____

Student's Date of Birth ____/____/____ SS#_____

Student's Address _____ *city* _____ *state* _____ *zip* _____

Student resides with ___Both parents ___Mother ___Father ___Guardian _____

Mother or Legal Guardian _____ Phone _____ Work or Cell _____

Father or Legal Guardian _____ Phone _____ Work or Cell _____

Emergency Contact _____ Phone _____ Work or Cell _____

MEDICAL INSURANCE INFORMATION
We will need a copy of the front and back of your insurance card. Please attach it to this form.

Policyholder's Name _____ Date of Birth _____ SS #_____

Insurance Company Name _____ Policy #_____ Group #_____

Address _____ city _____ state _____ zip _____

CONDITION	YES	COMMENTS	CONDITION	YES	COMMENTS
Allergies (food, insects, drugs, latex)			Diabetes (Type I or II)		
Allergies Seasonal			Head or spinal injury		
Asthma			Hearing/Vision problems		
Attention Deficit Hyperactive Disorder			Heart problems		
Behavioral problems			Headaches/Migraines		
Developmental problems			Psychological problems		
Bladder problems			Seizures		
Bleeding problems			Sleep Walking		
Contact Lenses			Sickle Cell (not Trait)		
Eating Disorder			Sinus Problems		
Dental problems			**date of last tetanus booster**		

Describe any other important health-related information about your child. (Attach an additional sheet if necessary.)

_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly. (Attach an additional sheet if necessary.)
International Students must have all medications translated into English before bringing them to campus.

_____

_____

I give the Health Center staff permission to administer over-the-counter medication or prescription medication to my child as prescribed by a licensed physician . **My child will have valid health insurance coverage throughout her time at St. Margaret's School. I understand that I must provide this coverage and evidence of my child's coverage by producing a valid insurance card and providing updated information as it becomes available. I acknowledge receipt of the Student Health Polices and confirm reading and understanding off information contained on that page.**

Signature of Parent or Legal Guardian _____ Date _____

TREATMENT AUTHORIZATION
I authorize the physician, school nurse, or other health professional to render necessary medical care to my child/ward named above. I understand that this authorization does not include medical care beyond that which is usual and customary for routine or emergency treatment. However, in the event of an emergency, and if I am unable to be reached by the school, hospital, nurse, or physician, as the case may be, I consent for St. Margaret's School to act on my behalf in granting permission for medical treatment, including surgery requiring the use of an anesthetic. This authorization shall be in effect as long as my child is a student at St. Margaret's School. I give permission to release medical information regarding my child to the faculty and/or administration at St. Margaret's School and other health care providers as necessary. This information will be released on a need-to-know basis and will be kept confidential by those persons.

Signature of Parent or Legal Guardian _____ Date _____

St. Margaret's School

PART II: COMPREHENSIVE PHYSICAL EXAM FORM

Physical examination must be completed by a qualified licensed physician, nurse practitioner or physician assistant.

Student's Name _____ Date of Assessment _____

Date of Birth _____ Sex _____ Weight (lbs.) _____ Height _____ ft. _____ in.

Body Mass Index (BMI) _____ BP _____ Pulse _____ Urinalysis _____ Hemoglobin _____

Required TB Risk Assessment _____

Date of Meningococcal Vaccine _____ Date of last Tetanus Booster _____

PHYSICAL EXAM		
HEENT	Abdomen	Urinary
Lungs	Extremities	Neurological
Heart	Skin	Genital

VISION / HEARING	
Eyes: R20/ L20/	Hearing: R+ L+
Wears glasses	Hearing aid
Contact lenses	

***IMMUNIZATIONS**

All students must show proof of immunization as mandated by Virginia State Law. Immunization records must be obtained before school admission. **SMS also requires a yearly TB Risk Assessment regardless of prior BCG vaccination. Boarding students must have proof of immunization before entry to dormitories.**

INTERVENTION

Summary of findings: (check one)

- ☐ Well child: no condition identified of concern to school program activities.
- ☐ Conditions identified that are important to schooling or physical activity. (Complete sections below and/or explain here. Attach an additional sheet if necessary.)

_____

_____

☐ Allergy: Food _____ Insect _____ Medication _____ Other _____

Type of allergic reaction: ___ Anaphylaxis ___ Local Reaction _____

Response required: ___ None ___ Epi-Pen ___ Other _____

☐ Individualized Health Care Plan needed (e.g. asthma, diabetes, seizure disorders, severe allergy, etc.)

Medications: Please list medications child takes for specific health conditions:

_____

_____

Special Diet _____ or Special Needs _____

Other comments _____

HEALTH CARE PROFESSIONAL'S CERTIFICATION (write legibly or stamp)

I certify that I have on this date examined this student and find her physically able to compete in supervised activities such as: baseball, basketball, crew, cross country, field hockey, golf, kayaking, rock climbing, soccer, skiing, snowboarding, swimming, tennis and volleyball.

Name _____ Signature _____ Date ____/____/____

Practice/Clinic Name _____ Address _____

Phone _____ Fax _____ E-Mail _____

St. Margaret's School

PART III: CERTIFICATION OF IMMUNIZATION

Section I
To be completed by a physician, registered nurse, or health department official.

A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name _____ Date of Birth _____/ _____/ _____
last first middle month day year

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus inuenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

* Required vaccine

I certify that this child is **adequately or age appropriately immunized** in accordance with the **minimum** requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (minimum requirements are listed in Section III).

Signature of Medical Provider or Health Department Official _____ Date _____ / _____ /_____
month day year

St. Margaret's School

PART III: CERTIFICATION OF IMMUNIZATION
(Continued)

Student's Name _____ Date of Birth _____/ _____/ _____
last first middle month day year

Section II
Conditional Enrollment and Exemptions
Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION
As specified in the Code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

DTP/DTaP/Tdap___ DT/Td___ OPV/IPV___ Hib___ Pneum___ Measles___ Rubella___ Mumps___ HBV___ Varicella___

This contraindication is permanent ___ or temporary ___ and expected to preclude immunizations until: Date ____/ ____/ _____
month day year

Signature of Medical Provider or Health Department Official _____ Date _____ / _____ /_____
month day year

RELIGIOUS EXEMPTION
The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a Certificate of Religious Exemption (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT
As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____

Signature of Medical Provider or Health Department Official _____ Date _____ / _____ /_____
month day year

Section III
Requirements

For minimum immunization requirement for entry into school and day care, consult the Division of Immunization website at www.vdh.virginia.gov/epidemiology/immunization.

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (ref. *Code of Virginia* § 32.1-46 (a)). Requirements are subject to change.

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TB RISK ASSESSMENT QUESTIONNAIRE

to be completed by your child's physician

Student's Name _____

1. Was the child born outside the United States? __ YES __NO

If yes, where? _____

If the child was born outside of the United States, a PPD/TST should be placed.

2. Has the child traveled outside the United States? __ YES __NO

If yes, where did the child travel, with whom did the child stay, and how long did the child travel?

_____

If the child stayed with friends or family members in Africa, Asia, Latin America, or Eastern Europe for more than one week, a PPD/TST should be placed.

3. Has the child been exposed to anyone with TB disease? __ YES __NO

If confirmed that the child has been exposed to someone with suspected or known TB disease, a PPD/ TST should be placed.

4. Does the child have close contact with a person who has a positive TB skin test? __YES __NO

Follow-up same as question # 3

PPD/ TST REQUIRED? __YES __NO

Date Given _____Date Read_____Results_____MM_____

If positive, it will be necessary to document a normal chest X-ray or treatment for INH Treatment.

Date of chest x-ray _____ Results _____

Date INH began _____

Signed _____MD

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INFLUENZA VACCINATION PERMISSION FORM
2018-2019

To minimize the impact of an influenza outbreak on campus, the Health Center will again offer the influenza vaccine. Our Health Center nurses will vaccinate all students against the influenza virus, unless notified in writing (see below) that you do not wish to have your daughter vaccinated. All vaccines have the potential to cause side effects or reactions. People with serious allergic reactions to eggs cannot take the vaccine. Please discuss these issues with your physician or feel free to contact our nurses.

We generally begin vaccinating in late October or early November as recommended by the Centers for Disease Control in Atlanta, Georgia. The cost of the vaccine will be billed to the student's account if administered on campus. If you have any questions, please contact the nurses at the Student Health Center.

Please complete and return this form along with the student health information form, physical exam form, immunization form, TB risk assessment form, and a copy of your health insurance card to:

St. Margaret's Health Center
P.O. Box 158
Tappahannock, Virginia 22560

YES, You may administer the influenza vaccine to my child, _____.
(student's name)

NO, You may not administer the influenza vaccine to my child, _____.
(student's name)

She is allergic to eggs

Other (please explain) _____.

Parent or Guardian name _____ signature _____

date _____