



## American Hebrew Academy

June, 2011

Dear American Hebrew Academy parents of returning students:

On behalf of the Health Center Staff I want to welcome you and your student back to the Academy.

Enclosed, please find the revised returning students' Health Center forms which should be completed by a parent or guardian and returned by July 15<sup>th</sup>. With several forms, only a parent signature is needed. Other areas require a bit more information. Please be sure to not only complete the forms with updated information, but also let us know if any changes are made throughout the school year.

**These forms are very important and all are all necessary if we are to complete the health record and provide your student with the best possible and timely healthcare.**

Please note the following regarding the forms you are being asked to complete:

### Physician's Medical Exam (PE):

We must have a current physical on file at the Student Health Center (SHC). This means that the exam, at no time, can be more than one year (365 days) old. Most parents find it convenient to have this exam completed each summer in order to not have to worry about it during the school year when having the exam may be less convenient. Please note the section on the back of the PE which the parent should complete prior to taking it to the physician. Transportation is not provided to students for regular yearly physical exams. It is expected that this will be taken care of at home.

### Immunization Record:

It is not necessary to complete this form again. **Only updates are necessary.** The Health Center Staff as well as Dr. Kaplan (our medical advisor) strongly recommend that your female and male students be immunized with the Gardasil vaccine. All students living in a boarding school environment should receive the Menactra (meningitis) vaccine. (Please see the second and third page of the Immunization form for required immunizations as well as those that are strongly recommended.) If you have any questions or concerns, be sure to discuss the need for all vaccines with your child's pediatrician or general practitioner prior to the start of school.

### Medication Orders:

We must have a **new** medication order for each medication your student is taking this coming school year. **This includes both prescription and non-prescription (over the counter) meds taken regularly (herbals included).** Please give the medication order form to your student's physician to complete and be sure the name of the physician and office number is legible. For field trips over two days, we will need an **additional container** for each medication prescribed for your child. You can ask your pharmacist for an additional labeled (empty) container. Also, it would be helpful if you maintain a supply of your child's medications at home to be available for vacations or weekends should your student forget to get them from the Health Center before leaving.

### Current Health Information:

We need this concise, updated form to be placed in a readily accessible area record in your student's chart. Thank you for completing this information.

### Over the Counter (OTC) Medication Administration to students:

As you know, most medications are administered by the nurses at the Health Center. **All** prescription and non-prescription medications **must be registered** at the Health Center. **All students and parents are required to check in with the nurses upon arrival whether or not they have medications to report. Please be sure to bring all medications to the Health Center table on the day your student arrives to campus in August.** Last year you completed the OTC form and the directions you gave will stand for this year.

For those parents who are physicians, please resist the temptation to diagnose over the telephone or internet and to prescribe medications for your child while he/she is at the Academy

### A note about confidentiality:

#### **STATEMENT TO PARENTS CONCERNING NORTH CAROLINA LAW**

Adolescents often need health care related to sexual issues such as contraception or sexually transmitted infections (STI) as well as other sensitive issues which they are reluctant to seek help for due to embarrassment or privacy issues. Ultimately, if adolescents cannot obtain confidential health care, they are placed at risk. Numerous health care organizations and providers have developed policies that affirm the importance of providing confidential healthcare to adolescents. State laws including those in North Carolina support the need to provide adolescents with access to confidential contraception services even when abstinence is strongly encouraged. This follows Academy policy and U.S. Supreme Court rulings that extend the constitutional right to privacy to minors who wish to obtain contraceptives. The Health Center staff always encourages students to discuss their health care needs with their parents first, and while parental guidance is best in

such circumstances, parents are advised that minors can confidentially request contraceptives or STI testing from a doctor or other health care professionals. The Academy's health center does not distribute contraceptives or condoms to students but does conform with applicable law by ensuring minor's confidential access to contraceptive services if requested and provided by doctors.

*North Carolina General Statutes 90-21.5. Minor's consent sufficient for certain medical health services reads: (a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.*

Pursuant to this law the Academy Health Center staff may not disclose medical records of students related to the prevention, diagnosis and treatment of venereal disease and other sexually transmitted diseases, pregnancy, abuse of controlled substances or alcohol and emotional disturbance without the written consent of the student. However, in conformity with Academy policy, the Academy will advise parents whenever they transport a student to a doctor for any reason, the name of the doctor and their contact information. It is then up to the parent to contact their child to discuss their medical treatment.

In practice when a student presents to the Health Center requesting counseling or medical care that is of a sexual nature, the nursing staff will refer the student to a health care professional as deemed appropriate. If a referral is made or requested, we will inform the parents of the referral and provide them with the name of the doctor, address, and phone number, but we will not reveal the nature of the referral.

**Credit Card Information:**

We must have a current credit card on file (unless your student is local and non-boarding) in order to provide your student with pharmacy co-pays and other medical needs. Please be sure to send us any changes to this card throughout the school year. You will be sent the receipts after any charges are made to your card.

**Consent for Influenza Vaccine:**

We are fortunate to be able to provide your student with the influenza vaccine. For the past several years, we have seen very little flu activity on this campus. This can partially be attributed to the fact that over 75% of our students and faculty are immunized each year. We encourage you to allow your student to be immunized. Please review the permission form and if your child is eligible for the vaccine (not the flu mist), complete it and return the form by July 15<sup>th</sup>. Since we must know how much vaccine to order, we must hear from you by this date. If the form is received after July 15<sup>th</sup> your student's name will be placed on a waiting list for the vaccine.

Although mentioned in previous letters I would like to re-emphasize that as with other aspects of life at the American Hebrew Academy, all students will need to take some responsibility for their own health. For example, they will need to seek medical attention when they become ill or injured, take their medications as prescribed, and keep all of their follow-up medical appointments by arriving on time to the Health Center for transportation. Additionally, students must remember to collect their medications prior to going home for vacations (if they are needed at home).

Students who are ill are required to come to the SHC for assessment and evaluation. If excused from classes due to illness, they are expected to remain at the SHC until released. We will not necessarily inform you every time that your child visits the Student Health Center for routine issues. However, we will contact you if your child needs to travel off campus for medical care. You will also be notified if your child must remain in the SHC overnight. Generally, we will not inform you if your student is ill and at the SHC for one day. If your student is ill for more than two consecutive days however, we will let you know. Of course you are always welcome to call us with any concerns you may have.

For the welfare of your child and the entire school community, you are required to inform us of any potentially infectious medical conditions your child may have, e.g., chronic viral hepatitis, tuberculosis, HIV infection or AIDS. Such information will remain completely confidential and will not be released to anyone without your permission unless required by law.

Always feel free to contact us at any time you have questions or concerns about your child's health.

Sincerely,

*Ruth L. Hoffman*

Ruth Hoffman, R.N., M.S.N.  
Director of Health Services  
Telephone: (336) 217-7000 Ext. 8888  
Health Center telephone: (336) 217-7080  
Fax: (336) 217-7132

**PLEASE MAKE PHOTOCOPIES OF ALL COMPLETED FORMS FOR YOUR RECORDS AND RETAIN THIS INFORMATION FOR FUTURE REFERENCE**



**PHYSICIAN'S MEDICAL EXAMINATION  
2011-2012**

**TO THE EXAMINING PHYSICIAN:**

**DATE OF EXAM** \_\_\_\_\_

This student has been accepted to the American Hebrew Academy. In a boarding school environment, it is very important that we have thorough and current medical information on all students. **Please note that the American Hebrew Academy Health Center will NOT accept a medical examination that took place more than 12 months ago.** Thank you for your assistance.

Student's Name \_\_\_\_\_  
(Please Print) Last First Middle

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male  Female   
Month Day Year

Blood Pressure \_\_\_\_/\_\_\_\_ Pulse (reg /irreg)\_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_

Allergies (food/drug & reaction) \_\_\_\_\_

Most recent PPD-Mantoux skin test: Date: \_\_\_\_\_ mm. Induration \_\_\_\_\_

(Required within the past 2 years for all students born or currently living in Eastern Europe, Asia, (except Japan), Africa, Central America and South America or for ANY student who has been exposed to tuberculosis.)

**A RECENT PPD MAY BE REQUIRED FOR FOREIGN STUDENTS AND ANY STUDENT WITH A HISTORY OF EXPOSURE TO TUBERCULOSIS**

CXR if PPD is positive: Date/Result \_\_\_\_\_ INH Treatment? \_\_\_\_\_

**IMMUNIZATION RECORDS – SEE SEPARATE FORM “IMMUNIZATION RECORD”**

**VISION SCREENING (OPTIONAL)**

| EYE          | FAR | NEAR |
|--------------|-----|------|
| RIGHT (O.D.) |     |      |
| LEFT (O.S.)  |     |      |

CORRECTION (CIRCLE) Y N

| TEST           | PASS | FAIL | N/A |
|----------------|------|------|-----|
| MUSCLE BALANCE |      |      |     |
| BINOCULARITY   |      |      |     |
| COLOR VISION   |      |      |     |

**HEARING SCREENING (OPTIONAL)**

**RECORD FREQUENCY THRESHOLDS IN DB.**

| EAR          | 500 HZ. | 1000 HZ. | 2000 HZ. | 4000 HZ. |
|--------------|---------|----------|----------|----------|
| RIGHT (A.D.) |         |          |          |          |
| LEFT (A.S.)  |         |          |          |          |

**PHYSICAL EXAMINATION**

| SYSTEM            | NORMAL | ABNORMAL | PLEASE DESCRIBE ABNORMALITY |
|-------------------|--------|----------|-----------------------------|
| HEENT             |        |          |                             |
| NECK/THYROID      |        |          |                             |
| CHEST/RESPIRATORY |        |          |                             |
| CARDIOVASCULAR    |        |          |                             |
| ABDOMEN           |        |          |                             |
| GENITOURINARY     |        |          |                             |
| MUSCULOSKELETAL   |        |          |                             |
| SKIN              |        |          |                             |
| NEUROPSYCHIATRIC  |        |          |                             |



**PHYSICIAN'S EXAM CONTINUED:**

1. DOES THE STUDENT HAVE ANY CHRONIC MEDICAL CONDITIONS? IF YES, PLEASE COMMENT. YES NO

2. DOES THE STUDENT HAVE A PSYCHIATRIC CONDITION, ATTENTION DISORDER, HISTORY OF SUBSTANCE ABUSE, EATING DISORDER, OR SLEEPING DISORDER? IF YES, PLEASE COMMENT. YES NO

3. RECOMMENDATIONS FOR PARTICIPATION IN ATHLETIC ACTIVITIES, (PLEASE EXPLAIN) INCLUDING CONTACT SPORTS. PLEASE NOTE ANY RESTRICTIONS. UNLIMITED LIMITED

4. DO YOU HAVE ANY OTHER SPECIFIC RECOMMENDATIONS REGARDING THE MEDICAL CARE OF THIS STUDENT? IF YES, PLEASE EXPLAIN. YES NO

5. I REVIEWED AND SIGNED THE OVER-THE-COUNTER MEDICATION FORM YES NO

6. PLEASE LIST ALL MEDICATIONS (RX & OTC) TAKEN REGULARLY AND THEIR DOSES: (NOTE: A DETAILED SEPARATE MEDICATION SHEET IS REQUIRED)

| MEDICATION | DOSE/AGE |
|------------|----------|
| _____      | _____    |
| _____      | _____    |
| _____      | _____    |

NAME OF EXAMINING PHYSICIAN/PRACTITIONER (PLEASE PRINT) \_\_\_\_\_

SIGNATURE OF EXAMINING PHYSICIAN/PRACTITIONER \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_ EMAIL \_\_\_\_\_

PARENTS COMPLETE THE FOLLOWING PRIOR TO VISITING THE PHYSICIAN:

1. HAS ANYONE IN THE FAMILY (GRANDMOTHER, MOTHER, FATHER, BROTHER, SISTER) DIED SUDDENLY BEFORE THE AGE OF 50? Y N

2. HAS THE STUDENT EVER STOPPED EXERCISING BECAUSE OF DIZZINESS OR PASSED OUT DURING EXERCISE? Y N

3. HAS A PHYSICIAN EVER TOLD YOU OR YOUR STUDENT THAT HE/SHE HAS A HEART MURMUR? Y N

4. HAS THE STUDENT EVER HAD A BONE BROKEN, HAD TO WEAR A CAST, OR HAD AN INJURY TO ANY JOINT? Y N

5. DOES THE STUDENT HAVE ASTHMA (WHEEZING) HAY FEVER OR COUGHING SPELLS DURING EXERCISE? Y N

6. DOES THE STUDENT HAVE A HISTORY OF A CONCUSSION (BEING KNOCKED OUT)? Y N, IF YES, PLEASE EXPLAIN \_\_\_\_\_

7. DOES THE STUDENT HAVE A CHRONIC ILLNESS OR SEE A DOCTOR REGULARLY FOR ANY PARTICULAR PROBLEM? Y N

8. DOES THE STUDENT HAVE ONLY ONE OF ANY PAIRED ORGANS (EYES, EARS, KIDNEYS, TESTICLES, OVARIES, ETC.) Y N

PLEASE ELABORATE ON ANY POSITIVE ANSWERS: \_\_\_\_\_

NAME OF PARENT/GUARDIAN (PRINT) \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



**MEDICATION ORDER 2011-2012**

To be completed by the licensed prescriber for each prescription medication and any non-prescription medication (including herbals) that is to be administered on an ongoing basis. (If additional space is necessary, please complete on back.)

Student name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Medication #1** \_\_\_\_\_ **Date of Order** \_\_\_\_\_ **D/C Date** \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ weekends (circle one): included excluded

Specific Directions for Administration \_\_\_\_\_

Diagnosis (please include ICD 9) \_\_\_\_\_

Has patient received education about medication/dosage/possible side effects? \_\_\_\_ Yes \_\_\_\_ No

Are there side effects, contraindications, or possible adverse reactions to be observed beyond current information that is referenced in the PDR?

**Medication #2** \_\_\_\_\_ **Date of Order** \_\_\_\_\_ **D/C Date** \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ weekends (circle one): included excluded

Specific Directions for Administration \_\_\_\_\_

Diagnosis (please include ICD 9) \_\_\_\_\_

Has patient received education about medication/dosage/possible side effects? \_\_\_\_ Yes \_\_\_\_ No

Are there side effects, contraindications, or possible adverse reactions to be observed beyond current information that is referenced in the PDR?

**(Please record other medications on back of this sheet)**

Are there other medical conditions? \_\_\_\_\_

Are there any other medications being taken? \_\_\_\_\_

Are there any known drug allergies? \_\_\_\_\_

Are there side effects, contraindications, or possible adverse reactions for any of these medications to be observed beyond current information that is referenced in the PDR? \_\_\_\_\_

Are there any non-prescription medications NOT advised for this student? \_\_\_\_\_





I recommend this student for self-medication administration provided the Health Center Staff agrees: YES NO

Medication #3 \_\_\_\_\_ Date of Order \_\_\_\_\_ D/C Date \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ weekends (circle one): included excluded

Specific Directions for Administration \_\_\_\_\_

Diagnosis (please include ICD 9) \_\_\_\_\_

Has patient received education about medication/dosage/possible side effects? \_\_\_\_ Yes \_\_\_\_ No

Are there side effects, contraindications, or possible adverse reactions to be observed beyond current information that is referenced in the PDR?

Medication #4 \_\_\_\_\_ Date of Order \_\_\_\_\_ D/C Date \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_ weekends (circle one): included excluded

Specific Directions for Administration \_\_\_\_\_

Diagnosis (please include ICD 9) \_\_\_\_\_

Has patient received education about medication/dosage/possible side effects? \_\_\_\_ Yes \_\_\_\_ No

Are there side effects, contraindications, or possible adverse reactions to be observed beyond current information that is referenced in the PDR?

**(Please record other medications on back of this sheet)**

Any other medical conditions? \_\_\_\_\_

Other medications being taken by student: \_\_\_\_\_



**Licensed Prescriber:** (Please write legibly or use stamp)

Name and Title (Please print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_ e-mail \_\_\_\_\_

Business phone (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

American Hebrew Academy Health Center  
4334 Hobbs Road. Greensboro, North Carolina, 27410  
Tel: (336) 217-7080, Fax: (336) 217-713





## Detailed Explanation of North Carolina State Immunization Requirements

### IMPORTANT NOTES FOR ALL VACCINES:

1. Half doses are **NOT ACCEPTABLE** and **CANNOT** be counted as fulfilling the dose requirement. **ONLY FULL DOSES** can be counted.

2. Immunizations received after 7/1/79 must be documented according to month-day-year. **Complete dates are required on school records.**

### VACCINES

**DPT\***: 5 doses required, 3 by age seven months and 2 booster doses, one by age 19 months and the second on or after the fourth birthday.

#### Exceptions:

1. An individual who has attained the seventh birthday without being immunized against whooping cough shall not be required to be immunized against whooping cough.
2. Individuals who receive the first booster dose of diphtheria, tetanus, and whooping cough vaccine on or after the fourth birthday shall not be required to have a second booster dose.

\*One booster dose of Tdap (Tetanus/Diphtheria/Pertussis) vaccine is required for individuals enrolling in college or universities for the first time on or after July 1, 2008 if it has been at least 5 years since their last dose of tetanus-containing vaccine.

**Polio**: 4 doses required; 2 doses of trivalent type by age five months; a third dose of trivalent type by age 19 months and a booster dose of trivalent on or after the fourth birthday.

#### Exceptions:

1. Three (3) doses are acceptable if the third dose was given on or after the fourth birthday.
2. Enhanced-potency inactivated (**IPV**) vaccine – Two doses of **IPV** may be substituted for two doses of **OPV**.
3. An individual attending school who has attained 18 years of age or older, shall not be required to receive polio vaccine.

**Measles**: 2 doses required of live, attenuated vaccine administered at least 28 days apart. One dose on or after the age of 12 months and before age 16 months. The second dose should be received before enrolling in school (K-1) for the first time.

#### Exceptions:

1. An individual who has been diagnosed prior to 1/1/94, by a licensed physician, as having measles (rubeola) disease is NOT required to receive vaccine.
2. Students who enrolled in school (K-1) for the first time BEFORE 7/1/94 are NOT required to receive a second dose of vaccine.
3. An individual who has been documented by serological testing to have a protective antibody titer against measles shall NOT be required to receive measles vaccine.

**Mumps\***: 1 dose required of live, attenuated vaccine administered on or after age 12 months and before age 16 months.

\*a second dose of Mumps vaccine is required for individuals enrolling in schools, colleges or universities for the first time after July 1, 2008

#### Exception:

1. An individual who has been documented by serological testing to have a protective antibody titer against mumps shall NOT be required to receive mumps vaccine.

**Rubella**: 1 dose required of live, attenuated vaccine on or after age 12 months and before age 16 months.

#### Exception:

1. An individual who has been documented by serological testing to have a protective antibody titer against rubella shall not be required to receive rubella vaccine.

**Hepatitis B (HepB)**: 3 doses, one dose by age three months, a second dose by age five months, and a third dose by age 19 months (not before 24 weeks old).

#### Recommendation:

1. Individuals born on or before 7/1/94 are NOT required to have vaccine. However, it is highly recommended by the Medical Advisory Committee of the American Hebrew Academy that your student receive HepB vaccination.

**Hemophilus Influenza, Type B (Hib)**: 4 doses: 3 doses of HbOC or 2 doses of PRP-OMP by age seven months and a booster dose of any type on or after age 12 months and by age 16 months.

#### Exceptions:

1. An individual who has passed his/her fifth birthday is NOT required to receive Hib vaccine.

**Varicella**: One dose administered on or after age 12 months and before 19 months.

#### Exceptions:

1. An individual who has been documented by serological testing to have a protective antibody titer against Varicella shall NOT be required to receive Varicella vaccine.
2. An individual who has documentation of previous illness by written statement from—a Healthcare Provider is NOT required to receive the Varicella vaccine.
3. Individuals born prior to 4/1/2001 shall not be required to receive Varicella vaccine.



In June, 2006 ACIP (Advisory Committee on Immunization Practices) recommended a second dose of Varicella vaccine for children 12 months through 12 years, effectively making a second dose of Varicella vaccine recommended for children 12 months through 18 years of age.

### **Other ACIP (Advisory Committee on Immunization Practices) Recommendations:**

#### **HEPATITIS A:**

ACIP recommends that all children 12 months through 18 years of age should receive two doses of Hepatitis A vaccine: The first dose to be administered after 12 months of age with a minimum 6 month interval between the first and second dose.

#### **MENINGOCOCCAL (Menactra):** ACIP recommends routine vaccination of adolescents:

1. Preferably at age 11 or 12 years old with a booster dose at 16 years old
2. One time booster dose at age 16 – 18 years old for individual who received the first dose of meningococcal vaccine at age 13 – 15 years old.
3. Individuals who received the first dose at age 16 years old do not need a booster dose.

The medical advisor for AHA (American Hebrew Academy) recommends that high school students living in a dorm setting be vaccinated as well.

#### **INFLUENZA (FLU):** Annual vaccination is recommended for all children ages 6 months to 19 years of age.

#### **HUMAN PAPILLOMAVIRUS:**

ACIP recommends routine vaccination of females and males aged 11-12 years of age with 3 doses of HPV. Vaccination is also recommended for females and males 13-26 years who have not been previously vaccinated or who have not completed the full series.



**CREDIT CARD INFORMATION FOR HEALTH CARE  
2011-2012**

Dear Parents and Guardians,

While a student at the American Hebrew Academy your son/daughter may need medical care or pharmacy services. In order to accommodate the obligation to pay the practitioners, pharmacy, co-pay, or other charge at the time of service, we will need a credit card number, expiration date, and VIN (security) number, as well as your signature.

This form will be kept in a locked file and used only for necessary medical fees as mentioned above. A copy of every receipt will be sent to you as soon as possible after it is charged. Please complete the form below and return it with the other health forms by **July 15, 2011** and let us know of any changes as soon as they occur (336) 217-7080.

Thank you.  
Ruth Hoffman, RN, MSN

Student name \_\_\_\_\_

Credit card type: Master Card, Discover, Visa, Amex, other, (*circle one*)

Credit card number \_\_\_\_\_

Expiration date \_\_\_\_\_

VIN number (last three or four digits of the number on the back of the credit card) \_\_\_\_\_

Name as it appears on the credit card \_\_\_\_\_

*Please print*

*Signature of card holder* \_\_\_\_\_ *Date* \_\_\_\_\_



## CONSENT FOR INFLUENZA VACCINE 2011 – 2012

The American Hebrew Academy (AHA) Health Center is making the influenza vaccine (inactivated) available to all students. The vaccine will be administered in October or November and the charge should not exceed \$16.00. This charge will be billed to your student’s account. If you would like your student to receive the vaccine, please complete the form below and return it to the Health Center (Attn: Ruth Hoffman) at 4334 Hobbs Road, Greensboro, N.C., 27410 or by fax (336.217.7132), by **JULY 15, 2011**. **It is important that we receive this consent by the date listed above since we must know how much vaccine to order. If your form is received after July 15, 2011 your student’s name may be placed on a waiting list.**

**(Please let us know if your student receives the flu vaccine elsewhere.)**

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### INFLUENZA CONSENT FORM

Influenza is a contagious infection caused by a virus. An injection of the flu vaccine will not give anyone the flu, since the vaccine is made from killed viruses. Side effects from the vaccine are generally mild and occur infrequently. Side effects may consist of tenderness at the injection site, fever, chills, headaches, or muscular aches and may last up to forty-eight hours.

If the student is pregnant or suspected of being pregnant, she is not eligible to receive the vaccine without written consent from a physician.

I verify that the student named below has not had a severe reaction to eggs or to the influenza vaccine. Additionally I verify that my child has not had Guillian Bare’ Syndrome within six weeks of receiving the flu vaccine previously.

I understand that if my son/daughter has a serious reaction other than soreness at the injection site, she/he will be examined by a physician that has been designated by the American Hebrew Academy Health Center staff.

I have read the above information and will contact the American Hebrew Academy Health Center staff with any questions. I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to my daughter/son. By having signed this form, I agree that the American Hebrew Academy, its trustees and employees will not be liable for unknown and unforeseen conditions arising from my son/daughter receiving the influenza vaccine.

Name of Student \_\_\_\_\_

Parent/Guardian Name (print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

.....  
For office use only:

Given by \_\_\_\_\_, RN Date \_\_\_\_\_ Lot # \_\_\_\_\_

Location \_\_\_\_\_



CURRENT HEALTH INFORMATION FOR RETURNING STUDENTS: 2011 - 2012

Student Name \_\_\_\_\_ Student cell \_\_\_\_\_

Are there any new medical/emotional conditions? (Physical, mental/emotional, allergies, family changes (births, divorce, deaths, marriage, surgeries)

Current medications (must have med order from physician – (see medication order sheet)

Please list telephone/cell for each parent/legal guardian: (Star \* best number to reach) other emergency contacts information

Form with columns for Name, Address, Relationship, Home Phone, Business Phone, Cell Phone, Fax, Other for each parent/legal guardian and other emergency contacts information.

HEALTH INSURANCE INFORMATION

Please complete the request for information below and please ATTACH an ENLARGED and LEGIBLE copy of parent's insurance card, (front and back), for health insurance coverage you maintain for your child.

Form for health insurance information including Name of Insured, Date of Birth, Relationship to student, SS#, Employer, Employer's Address/Phone, Insurance Company, and Insurer's Address/Phone.

I hereby grant permission to the American Hebrew Academy Student Health Center or to any hospital or physician designated by them, to submit and to collect from my insurance carriers any and all appropriate charges that are incurred for services rendered to my child.. I further grant permission for the release of any medical information necessary to process said claims for my child.

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ (Please print full name)

Signature \_\_\_\_\_ Relationship \_\_\_\_\_

PLEASE CONTACT THE HEALTH CENTER TO REPORT ANY CHANGES IN THIS INFORMATION