Immunizations, Health Records and Medicines

Dear Parents / Guardians,

State law requires that students present evidence of several common immunizations at the time of their enrollment in school. Enclosed in the packet you will receive in the mail is an immunization record form which needs to be completed with a signature from the doctor's office and returned to the school prior to or on opening day.

In addition, we are required to ask that you arrange for your child to have a physical examination, and that this examination be reported on the enclosed form. If this exam has been performed within the past six months, it need not be repeated; simply duplicate the original report.

Finally, we have also enclosed in the packet the school's policies and permission form for the administration of medicines to a student while at school. Even if this is not currently an issue for your child, we encourage you to review the policies and keep the permission form on file. Additional copies are available at the school.

We appreciate your cooperation with these requirements, and we would be pleased to answer any questions in which you may have regarding this area.

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____
(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date:_____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Gender:**

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, Hep B-CpG, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			**Measles, Mumps, Rubella** (e.g., MMR, MMRV)	1		
	2				2		
	3			**Varicella** (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			**Meningococcal Quadrivalent** MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			**Meningococcal Serogroup B (Men B)** MenB-FHbp (Trumenba) MenB-4C (Bexsero)	1		
	4				2		
	5				3		
	6			**Seasonal Influenza** Inactivated (e.g., IIV4, RIV4, ccIIV4, IIV3, IIV3-HD, aIIV3, RIV3, IIV4-ID) Live Attenuated (e.g., LAIV, LAIV4)	1		
	7				2		
	8				3		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			**2009 H1N1 Influenza** Inactivated or Live	1		
	2				2		
	3			**Pneumococcal Polysaccharide** (PPSV23)	1		
	4				2		
	5			**Hepatitis A** (HepA, HepA-HepB)	1		
Pneumococcal Conjugate (PCV13, PCV7)	1				2		
	2			**Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV)	1		
	3				2		
	4				3		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			**Zoster** (Shingles) (RZV [Shingrix], ZVL [Zostavax])	1		
	2				2		
	3				3		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Other Vaccines:

Vaccine Type	Dose No.	Date

Serologic Evidence 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

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic evidence 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:

Emergency First Aid or
Medical Treatment Administration Form

The Massachusetts Department of Elementary and Secondary Education requires public and private schools to have annual written authorization to administer emergency first aid or medical treatment to all students.

Such administration may include, but is not limited to:

Administering emergency first aid procedures; including applying pressure, administering bandages, gauzes, adhesives, band aids, first aid cream, burn aids, eye wash, and/or cleaning solutions.

Westfield Fire Department emergency medical services (ambulance) will provide transportation to a medical facility if, in the opinion of the school, such transportation and related medical treatment appears to be required for your child. You will be called immediately at your emergency contact numbers that you have provided in such circumstances. If we are unable to contact you, we will call the emergency contact numbers you have given us. We will continue to try to contact you if we are not initially successful.

As White Oak School is committed to the safety of all students, please complete this form and return it to the School as soon as possible.

Student Name: _____

Printed Parent Name: _____

Parent/Guardian Signature: _____

Hospital of Choice: _____

Date: _____

Dear Parents and Guardians,

This letter is to inform you of the White Oak School policy for medication administration during the school day. To ensure the health and safety of children taking routine, as needed prescription or non-prescription medications, over the counter (OTC) medication, or emergency medication, the following forms must be completed and included in your child's health records on file at the Health Center prior to any medication administration for the school year.

1. Parental Consent for Medication Administration form for each prescription or nonprescription (OTC) medication, signed by a parent or guardian. A new form must be signed at the beginning of each school year before medication can be administered for that school year.

2. Completed Medication Order form for each prescription or nonprescription (OTC) medication, signed by your child's licensed prescriber (your child's physician, nurse practitioner, etc.). This order will be valid only for the current school year unless otherwise indicated on the form by the prescriber.

All student medications, including nonprescription (OTC) medications, must be delivered to the Health Center, in the original medication bottle and kept in the medication cabinet at the Health Center.

The White Oak School does not stock any OTC, non-prescription medications at the Health Center.

For your convenience, all required medical forms are available at the Health Center and on the White Oak School website, www.whiteoakschool.org, go to Resources and choose Health Services.

Please send all completed medical forms to me before the start of the school year, by USPS, by email at ssousa@whiteoakschool.org or by Fax at 413-562-9010 Attention: Sandra Sousa, RN. Please contact me by phone at 413-562-9500, Ext: 221 with your questions or concerns.

Parent/Guardian Consent for Medication Administration

A separate form must be completed for each prescribed or OTC medication.

Student _____ Date of Birth _____Grade _____

Printed name of Parent/Guardian _____

Home Phone _____ Work Phone _____

Cell or Other Emergency Contact Number _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all your child's daily and as needed medications:

_____

My son/daughter has the following allergies

_____

Consent

I give permission to the school nurse or school personnel designated by the school nurse, to give the following medication:

Ordered by (name of licensed prescriber): _____

I understand that I must supply the school with the prescribed or OTC medication in the original container dispensed and properly labeled by a physician, the pharmacy, or the company label in the case of over the counter (OTC) medications.

I understand that I may retrieve the medication from the school at any time and that the medication may be destroyed if it is not picked up within one week following termination of the medication order or if not picked up by the end of the school year.

I give permission to have the school nurse share with the appropriate school personnel information relative to the medicine administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughter's health and safety. **Yes** ◯ **No** ◯

List any restrictions on sharing information _____

Signature of Parent/Guardian _____

Relationship to Student _____ **Date** _____

MEDICATION ORDER

(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Student _____ **Date of Birth** _____

Medication _____ **Dosage** _____

Route of Administration _____ **Frequency** _____

Time(s) to be administered at school _____

Condition for which drug is being administered _____

For treatment for allergic reaction, please specify specific symptoms:

_____

Medication side effects, contraindications, or possible adverse reactions:

_____

Consent for self-administration, provided the school nurse determines it is safe and appropriate:
Yes ◯ **No** ◯

Date of Order _____ **Discontinuation Date** _____

Name of Licensed Provider _____

Signature of Licensed Prescriber _____

Optional Information

1. Any other medical condition(s)* _____

2. Other medications being taken by the student: _____

3. Date of the next scheduled visit or when advised to return to prescriber: _____

**if not in violation of confidentiality*

Reviewed 6/2024

Over-the-Counter First Aid Consent Form

I give permission for the school nurse to administer the following over the counter products or medications to (student name) _____ according to protocols established by White Oak School.

- Bactine Spray or Liquid: for temporary relief of pain and itching associated with minor cuts, scrapes, burns and insect bites.
- Calamine or Caladryl lotion: used for the relief of itching due to insect bites and poisonous plants or minor rashes.
- Triple Antibiotic Ointment: for external application to prevent infection in minor cuts, scrapes or burns.
- Ophthalmic saline solution: used for rinsing the eye or contact lenses.
- Sunscreen (any brand): for use to prevent sunburn during outdoor activities held during school hours.
- Any fragrance-free hand lotion.
- BZK Antiseptic Towelette: used for cleansing minor wounds and piercings.
- Hydrogen Peroxide: used for cleaning heavily contaminated wounds.

To the best of my knowledge, my child has no allergy or sensitivity to any of the above-named products or medications. I have CROSSED OUT AND INITIALED any product or medication I do not want given or used. I understand that I may call the school nurse for further information.
This form must be renewed each year.

Signature of Parent or Guardian _____ Date _____

Any medications to be administered to the student other than above, including over the counter medications, require a doctor's order and a completed parent/guardian consent form. These forms are available at the Health Center and online at www.whiteoakschool.org.

Please contact the school nurse with any questions and for additional information at 413-562-9500, Ext. 221.

Reviewed 6/2024

Over-the-Counter (OTC) Medication Policy

Please read carefully with your student and sign below!

1. Students needing nonprescription, over the counter, medication can receive those medications from the school nurse. There must be, on file at the Health Center, a completed Medication Order form, and a signed Parent/Guardian Consent for Medication Administration form for each medication. The medication must be provided by the parent/guardian, in the original medication packaging.

2. The school nurse will provide OTC medication administration between the hours of 8:30AM-3:30PM. In the case that the nurse is absent from school or not available, OTC medication administration may be handled by a trained designated staff member. The OTC medication is administered under conditions of "supervised self-administration." This means that the school will give the student the medication type and dosage according to the Medication Order and the Parent/Guardian Consent on file at the Health Center and following protocols established by the school nurse. In such cases, the school will ask the student to verbally verify that he or she is taking the correct medication and dosage. The school will enter a record of the administration into a log (coordinated with the school nurse), including the name of the medication, the dosage, and the time of administration. The school's designated staff member is not making a medical decision in any regard in relation to the OTC medication administration. The White Oak designated staff member is, in this case, supervising a self-administration of the OTC medication.

3. **The procedure (and definition) of "supervised self-administration" does not permit students to carry medications on their persons or in their belongings, nor to accept or use medications provided to them from any source. Possession or unsupervised use of OTC medications, and/or prescription-type medications by a student in a school is strictly prohibited under State law and may result in disciplinary action against a student.**

   Print Student Name _____

   Student Signature_____

   Parent/Guardian Signature: _____ Date: _____

Reviewed 6/2024

533 North Road, Westfield, MA 01085 • (413) 562-9500

Prescription and Non-Prescription Medications Form
AUTHORIZATION FOR MEDICATIONS

To be taken during school hours

THE FOLLOWING IS TO BE COMPLETED BY PARENT/GUARDIAN

School_____ Grade _____

Student's Name _____Sex _____Date of Birth _____
Last First

I request that my son/daughter be assisted in taking the medications(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

_____
Signature Parent/Guardian Home Phone Emergency Phone Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis for which medication is given _____

Name of Medication _____

Form _____Dosage_____ Time of medication if daily _____

If medication is to be given PRN describe indications _____

How soon can it be repeated?_____Can student medicate self? Yes ____ No ____

List significant side effects _____

Date to start_____ Date to stop _____

Other information _____

***Physician/Nurse Practitioner Signature _____Date _____**

Physician/Nurse Practitioner Name Print _____

Telephone Number _____

Reviewed 6/2024

Student Dental Screening Form

The Mass. Dept. of Public Health strongly recommends an annual dental screening for everyone in the state. In 2009, the Mass. Dept. of Elementary and Secondary Education requested that the White Oak School begin collecting and recording student information regarding annual dental screening. Please provide White Oak School with the following information.

Student Name: _____

Name of Dentist: _____

Dentist Telephone #: _____

Approximate date of last dental visit: _____

If the above date is not within this past year, please provide the date of the next scheduled dental appointment:

_____

Parent/Guardian Signature: _____

If you have any questions, please contact the school nurse at the Health Center, 413-562-9500 Ext: 221.

Reviewed 6/2024