



# The Greenwood School

2011/2012 School Year

14 Greenwood Lane, Putney, Vermont 05346

Phone: 802-387-4545 • Fax: 802-387-5396

July 22, 2011

Dear Parents:

This year in an effort to reduce paper, we are sending you the necessary medical forms via email.

Please print out the Physician's Report and take it with you when you take your son for his required yearly comprehensive physical. Please schedule over the summer any dental or orthodontic work, new glasses, etc. as it is often hard to fit this in during school breaks. We appreciate knowing your son is in the best of health to start the new year.

Please review the Immunization History form with your doctor to see your son meets the requirements. Tuberculin skin tests are now required for all students from outside of the U.S. The State of Vermont requires hearing and vision checks for all 5<sup>th</sup>, 7<sup>th</sup> and 9<sup>th</sup> graders. The State now also requires that we provide you with information about concussions and have you and your son sign that you have read it. We will be providing training to all staff, as well, updating concussion protocols.

Also please review the Medical Services portion of the Parent/Student Handbook. It provides you with a lot of information. As an addendum to the information in it, I would like to suggest that you do not send your son with chewable or gummy vitamins and supplements. In my experience most of the boys actually prefer to swallow a pill, rather than chew a vitamin, which leave an odd aftertaste in their mouth at mealtimes. It also streamlines and therefore makes safer the distribution of supplements and medications.

Please take the time to fill out the documents fully and accurately as this information helps use treat your son, especially in case of an emergency. Also provide in detail in writing any special situations that merit special monitoring or management. This will help us provide for the health and safety of your son. If your son receives more than one medication or supplement please include a schedule of medications to provide accurate administration.

I ask that you return the completed forms to Greenwood by August 15<sup>th</sup> as this will allow us to meet your son's medical needs right from the start and simplify the opening weekend for you and your son so more time can be spent settling in rather than filling out forms!

I look forward to seeing you all in September. Enjoy the rest of the summer with your son!  
And as always feel free to call me with any questions.

Sincerely,

Felicity Ladd, School Nurse  
(802) 387-5944 home/(802) 380-9334 cell

Attached you will find necessary medical forms including:

1. [Authorization to Dispense Over-the-Counter Medication;](#)
2. [Emergency Medical Release with a copy of your insurance card—front and back](#)
3. [Health and Medical Information-please update doctor information and medical issues;](#)
4. [Medical Record Release Form](#)
5. [Release of Student-Related Health Information](#)
6. [Documentation of Varicella \(Chickenpox\) Disease](#) (If Needed)
7. [Credit Card payment for Medications Release—if prescriptions will be filled while at school.](#)
8. [Non-Prescription/Natural Treatment Order and Permission Forms;](#)
9. [Physician's Report—a yearly physical is required with updated immunizations;](#)
10. [Prescription Medication Order and Permission for each prescription med;](#)
11. [Concussion information and signature sheet](#)



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## AUTHORIZATION TO DISPENSE OVER-THE-COUNTER MEDICATION

Student's Name: \_\_\_\_\_

The following is a list of over-the-counter (non-prescription) medications stocked by the school. 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 (OR GENERIC EQUIVALENT) LISTED BELOW, PLEASE PLACE A CHECK IN FRONT OF IT.**

For Ingestion:

- \_\_\_ Robitussin (Guaifenesin)
- \_\_\_ Robitussin DM (Guaifenesin/Dextromethorphan)
- \_\_\_ Benadryl (Diphenhydramine)
- \_\_\_ Sudafed (Pseudoephedrine HCl)
- \_\_\_ Claratin (Loratadine)
- \_\_\_ Acetaminophen (Tylenol)
- \_\_\_ Ibuprofen (Advil/Motrin)
- \_\_\_ Dramamine (Dimenhydrinate)
- \_\_\_ Cepacol Lozenges (Menthol/Benzocaine)
- \_\_\_ Pectin Throat Drops
- \_\_\_ Peptobismol (Bismuth subsalicylate)
- \_\_\_ Immodium (Loperamide HCl)
- \_\_\_ Maalox, Mylanta, Tums, Rolaids
- \_\_\_ Orajel
- \_\_\_ Peroxyl Mouth Rinse (hydrogen peroxide)
- \_\_\_ Emer'gen-C (Vitamin C and mineral drink)

\_\_\_ Other \_\_\_\_\_

For Topical Use:

- \_\_\_ Bactine Spray
- \_\_\_ Arnica (homeopathic)
- \_\_\_ Antibiotic Ointments such as Neosporin
- \_\_\_ Lamisil antifungal cream
- \_\_\_ Gold Bond Medicated Powder
- \_\_\_ Hydrogen Peroxide
- \_\_\_ Hydrocortisone 1% Cream
- \_\_\_ Lip Balm/Chapstick/Carmex
- \_\_\_ Caladryl
- \_\_\_ Visine Eye drops (Tetrahydrozoline HCl)
- \_\_\_ Sunscreen (30 SPF)
- \_\_\_ Aloe Vera Gel
- \_\_\_ Insect Repellent with DEET
- \_\_\_ Aquaphor Skin Lotion

\_\_\_ Other \_\_\_\_\_

This form must be signed and returned to the school. It will become a 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.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## EMERGENCY MEDICAL RELEASE FORM

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of last Tetanus Shot: \_\_\_\_\_

List all known Allergies: \_\_\_\_\_

Recent Medical History: \_\_\_\_\_

*(injuries, illnesses surgeries, seizures, allergic reactions, etc...)*

Current Medications: \_\_\_\_\_

Private Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy holder's Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_

*\*Enclose Copy of Insurance Card – Front and Back*

\_\_\_\_\_  
*Father/Legal Guardian*

\_\_\_\_\_  
*Mother/Legal Guardian*

\_\_\_\_\_  
*Street/PO Box*

\_\_\_\_\_  
*Street/PO Box*

\_\_\_\_\_  
*Town/City/Zip*

\_\_\_\_\_  
*Town/City/Zip*

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Cell Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Cell Phone**

Person(s) responsible for health care decisions: \_\_\_\_\_

If unable to contact you, please provide contact info for a friend, neighbor, or relative:

Name: \_\_\_\_\_ Phone : \_\_\_\_\_ h/w/c

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ h/w/c

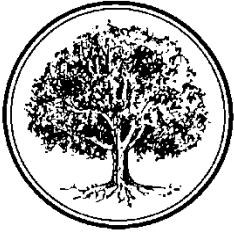
*I hereby give permission for The Greenwood School's physician or those designated to perform or delegate such medical procedures deemed necessary for minor illnesses or injuries. I hereby authorize emergency treatment for my son while he is enrolled at The Greenwood School and authorize release of any information necessary for treatment or collection of any charges incurred. I understand that no operation will be performed on a student, no hospital admission arranged, except in emergency, without parents be contacted and fully informed. I accept full responsibility for any charges for treatment that are not covered by the insurance company named above.*

\_\_\_\_\_  
Father/Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Legal Guardian's Signature

\_\_\_\_\_  
Date



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## HEALTH AND MEDICAL INFORMATION

Student's Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

*Street/PO Box*

SS#: \_\_\_\_\_

*Town/City/Zip*

Family Physician: \_\_\_\_\_

Last Appointment: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Family Dentist: \_\_\_\_\_

Last Appointment: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Family Orthodontist: \_\_\_\_\_

Last Appointment: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Psychiatrist/Psychologist : \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Current Medications (Prescription and Non-Prescription) \* If necessary please attach schedule of medication administration\***

Drug	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Hearing History**

Date of last Hearing Exam: \_\_\_\_\_ By Whom? \_\_\_\_\_

Ear/Hearing Problems: \_\_\_\_\_

*(Infection, injury, eartubes, etc...)*

**Vision History**

Date of last Vision Exam: \_\_\_\_\_ By Whom? \_\_\_\_\_

Glasses: \_\_\_\_\_

Contact Lenses: \_\_\_\_\_

Other Vision Problems: \_\_\_\_\_

*(Muscle problem, injury, surgery, etc...)*

**Oral History**

Date of last Dental Exam: \_\_\_\_\_ By Whom? \_\_\_\_\_

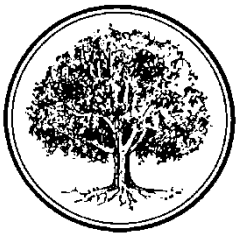
Orthodontics/braces: \_\_\_\_\_

Other Oral Health Problems: \_\_\_\_\_

*(Surgery, injury, etc...)***Other Significant Medical History (Describe on separate sheet if necessary)**

Health Problems	No	Yes	Explain
Allergies (please list): Food, Environmental, and Medications <i>Describe Reactions and Preferred Treatments</i>			
Arthritis/Joint Conditions			
Asthma* Circle One: <i>Mild / Activity Induced / Severe / Other</i>			
Bedwetting			
Bee Sting Reactions			
Bronchial/Respiratory			
Chicken Pox			
Chronic Illness			
Diabetes			
Diarrhea/Bowel Problems			
Eczema			
Fainting/Blackouts			
Fractures/Sprains			
Headaches			
Head Injuries			
Heart Conditions			
Attention/ Mental Health Issues			
Medication History <i>Please provide information on previous medications and doses to assist us in evaluation of current meds</i>			
Operations			
Physical Disabilities			
Pneumonia			
Scarlet/Rheumatic Fever			
Seizures/Epilepsy			
<b>Other:</b>			

**\*Doctor needs to send Asthma Action Plan**



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## Notice of Privacy Practice

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As parents, you have a right to privacy for your son's medical, dental and mental health information.

The Greenwood School must comply with the privacy standards mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This applies to all medical, dental and mental health information and records of its students and crosses the communication venues of phone calls, email, faxes and face-to-face conversations.

Below is a *Notice of Privacy Practice* all organizations handling protected health information, including Greenwood, must provide:

**Notice of Privacy Practice:** is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Privacy Practice is designed to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

\*the Plan's [Greenwood's] uses and disclosures of PHI;

### Dental Documents

*Greenwood arranges for dental care, including orthodonture, through local dental offices. Copies of related documents are transferred to these offices as needed. Dental offices must follow HIPAA guidelines.*

### Medical Documents

*The Greenwood School sends copies of medical information, provided by parents, to the following health care facilities. These facilities also must also follow HIPAA guidelines:*

*Brattleboro Pediatrics  
Brattleboro Memorial Hospital (Emergency & Registration))  
Brooks Pharmacy, Brattleboro, VT*

*The Greenwood School has copies of each student's medical information, provided by parents, in each of the 3 school vehicles. This provides your son with prompt medical attention should he be participating in an off campus activity.*

*The Greenwood School keeps on-campus documents in file cabinets and only those with a need-to-know have access.*

### Mental Health Documents

*Students at The Greenwood School occasionally require psychological or psychiatric (medicine management) services. The Greenwood School keeps on-campus documents in file cabinets and only those with a need-to-know have access. Typically these documents do not leave campus.*

Other Medical, Dental and Mental Health Information

*The Greenwood School has practices and policies to protect each students' privacy. This is done through limiting protected health information to only to those with a need-to-know. Phone calls to make doctor appointments or otherwise in regard to a student's health are made in privacy; person-to-person conversations take place behind closed doors. Faxes and emails from Greenwood in regards to medical or mental health information must contain a privacy statement.*

*Greenwood keeps a list of disclosures of each students' personal health information. Anyone who accesses a file must state the date, their name, and the reason why they are reviewing the material. At any time parents can request a copy of the(se) document(s).*

\*your privacy rights with respect to your PHI;

*Parents have the right to:*

*Receive, upon request, a list of disclosures of their son's personal health information.*

*Restrict access to any medical, dental or mental health documents on file at Greenwood.*

*Amend any medical, dental or mental health documents on file at Greenwood.*

*Receive an alternative method of communication with matters concerning their son's health.*

\*the Plan's [Greenwood's] duties with respect to your PHI\* ---and--- \*the person or office to contact for further information about the Plan's privacy practices.

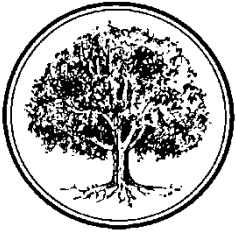
*The Greenwood School must provide safeguards to protect your son's personal health information, those safeguards are outlined above.*

*Greenwood provides a Privacy Officer (Anne Bebko) who oversees the use of personal health information of all students including the development, implementation, training and enforcing of policies and procedures to protect the privacy of protected health information. She is also the contact person responsible for receiving complaints and can provide further information about matters covered in this Notice.*

\*your right to file a complaint with the Plan [Greenwood] and with the Secretary of HHS

*Parents may file a complaint with The Greenwood School's Privacy Officer, Anne Bebko, 1-802-387-4545 X 108; abebko@greenwood.org. Parents also have the right to file a complaint with the US Secretary of Health and Human Services if they feel information has been misused. <http://www.hhs.gov/ocr/hipaa/>*

*Copy for parent to keep*



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## Medical Record Release Form

*I am in receipt and have read The Greenwood School's Notice of Privacy Practice and understand its contents. I can contact the school at any time if I have questions concerning the Notice.*

**I agree** to the disclosure of my son \_\_\_\_\_'s medical, dental and/or mental health forms as pertains to the Notice, particularly the sending of pertinent medical information to Brattleboro Memorial Hospital, Brattleboro Pediatrics and Brooks Pharmacy. I understand copies of my son's medical information will be placed in all Greenwood vehicles.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

*I am in receipt and have read The Greenwood School's Notice of Privacy Practice and understand its contents. I can contact the school at any time if I have questions concerning the Notice.*

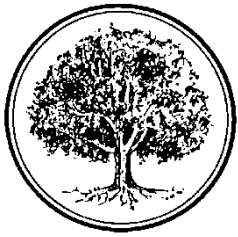
**I disagree**, or want to restrict my son \_\_\_\_\_'s medical, dental and/or mental health information per my statement below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

*Please return this page to school*



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## RELEASE OF STUDENT-RELATED HEALTH INFORMATION

### IN THE EVENT WE CANNOT GET IN CONTACT WITH YOU...

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) direct medical, psychiatric and dental information (including phone calls, faxes, face-to-face communications, and email) concerning your son cannot be relayed to our school nurse, Administrators or designated personnel, without your consent. For example: If your son has a suspected broken arm and we take him to the hospital for an x-ray we cannot directly talk to radiology personnel and receive the results of the x-ray without your consent. If for some reason we cannot get in contact with you this information would travel from the hospital to your personal physician before reaching us. Valuable time and care can be delayed as a result.

Your signature below will ensure your son gets immediate medical follow-up at The Greenwood School. All private medical, psychiatric and dental information concerning your son will remain protected by Greenwood personnel.

I, \_\_\_\_\_, give permission

for the Greenwood school nurse, administrators, and designated personnel to

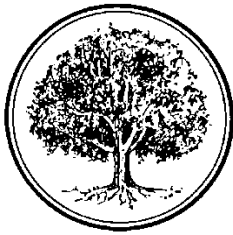
consult with my son \_\_\_\_\_'s health care provider(s)

including physician, dentist, psychiatrist, hospital personnel or Other (specify if needed): \_\_\_\_\_

as necessary concerning his medications or to discuss medical issues.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



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## Documentation of Varicella (Chickenpox) Disease



Vermont's School Immunization Regulations apply to students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations, including 2 doses of varicella (chickenpox) vaccine. However, students who have had chickenpox disease can still enroll provided this form be completed, signed and provided to the school. Please note that this form does not need to be signed by a physician or other health care provider.

This document is being submitted on behalf of the following student:

Name:

\_\_\_\_\_ Last

\_\_\_\_\_ First

Date of Birth :

\_\_\_\_/\_\_\_\_/\_\_\_\_

I \_\_\_\_\_ verify that the above listed student  
Parent/Guardian/Self (18 and over)

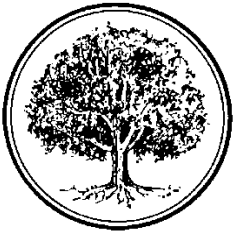
had varicella (chickenpox) disease in \_\_\_\_/\_\_\_\_.  
Month Year

\_\_\_\_\_  
Signature of parent or guardian of student or student 18 and over

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

The Vermont Department of Health  
Immunization Program  
108 Cherry Street  
Burlington, Vermont 05401

802-863-7638 or  
1-800-464-4343 ext. 7638  
healthvermont.gov



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## CREDIT CARD PAYMENT FOR MEDICATIONS RELEASE FORM

(Valid from September 2011 through June 2012)

I authorize the Greenwood employees listed below to pick-up medications on behalf

of \_\_\_\_\_  
Print Student's Name                      Date of Birth

And to pay for the medications upon pick-up using my credit card number:

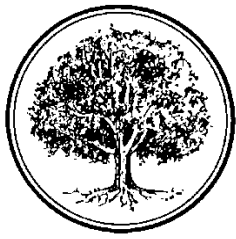
\_\_\_\_\_  
Credit Card Number              MC or V              Expiration Date              Billing Zip Code

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

Parent/Guardian: \_\_\_\_\_  
Print Name

### Greenwood Employees

Felicity Ladd  
Stewart Miller  
Reed Duncan



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## NON-PRESCRIPTION/NATURAL TREATMENT ORDER AND PERMISSION FORM

Includes all vitamins, over-the-counter, homeopathic remedies, lotions you wish given or are prescribed by a licensed prescriber. **PLEASE USE A SEPARATE FORM FOR EACH SUBSTANCE.**

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supplement/Treatment

\_\_\_\_\_  
Dose

\_\_\_\_\_  
Frequency

Beginning Date: \_\_\_\_\_

Last Dose: \_\_\_\_\_

Reason for Giving: \_\_\_\_\_

Special Instructions:

\_\_\_\_\_ If my son is on a prescription medication I have verified with his doctor that it may be given with this OTC.

I give permission for my son to receive the afore mentioned treatment at The Greenwood School and hereby absolve faculty/staff and the nursing department from any and all liability administering this substance or treatment at the request of the parent.

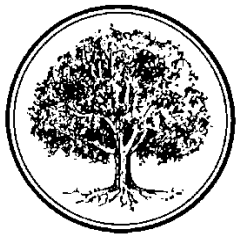
\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

No remedies will be given until the school receives this completed form **WITH THE REMEDY PROVIDED** in an appropriately labeled container. All medicines brought into the school must be kept in a locked storage area. Parents are responsible for supplying all over-the-counter medications that are to be given on a regular basis.

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Signature of School Nurse



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## PHYSICIAN'S REPORT

Student's Name: \_\_\_\_\_

Date of Examination: \_\_\_\_\_

The following information must be completed by a physician. This information will be used to compile our Vermont Health Annual Immunization Status Report. In the interest of the student, a physician who is a relative should not complete this form.

### IMMUNIZATION HISTORY – Please provide month, day and year in all entries

For an exemption a signed statement is required (available at the school)

**\*\*FOR RETURNING STUDENTS PLEASE UPDATE ANY NEW IMMUNIZATIONS\*\***

IMMUNIZATION	1	2	3	4	5
HIB					
DTP (Diphtheria, Tetanus, Pertussis)	*	*	*	**	**
DT (Pediatric, Diphtheria, Tetanus)					
Tetanus (note type) (* <i>Booster required age &gt;12</i> )					
Polio (note type)	*	*	*	**	
MMR (Measles, Mumps, Rubella)	*	*			
Chicken Pox ( <i>**Or lab proof of immunity Or parent signed form for history of disease**</i> )	**	**			
Flu Shot					
Meningococcal <b>**NOW REQUIRED**</b>	**				
Hepatitis B ( <i>By entry into 7<sup>th</sup> Grade</i> )	*	*	*		
Other					

*\*Required by the State of Vermont*

*\*\*Needed to meet new Vermont Requirements 8/2008*

### EXAMINATION REPORT

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Eyes Vision (with glasses, if worn): \_\_\_\_\_ Right: \_\_\_\_\_ Left: \_\_\_\_\_ Prescription: \_\_\_\_\_

Ears Hearing: \_\_\_\_\_ Right: \_\_\_\_\_ Left: \_\_\_\_\_ Tympanic Membranes: \_\_\_\_\_

Nose & Throat: \_\_\_\_\_ Chest & Lungs: \_\_\_\_\_

Teeth & Gums: \_\_\_\_\_ Heart Rhythm: \_\_\_\_\_ Murmur: \_\_\_\_\_

Lymph Nodes: \_\_\_\_\_ Abdomen: \_\_\_\_\_

Neck & Thyroid: \_\_\_\_\_ External Genitalia: \_\_\_\_\_

Orthopedic Abnormalities: \_\_\_\_\_

Spine (Scoliosis): \_\_\_\_\_

Neurological Abnormalities: \_\_\_\_\_

**Skin:** \_\_\_\_\_

**Lab Work:** \_\_\_\_\_

**Tuberculin Test (strongly suggested):** \_\_\_\_\_ Chest X-Ray (if positive)

**Urinalysis:** \_\_\_\_\_

**Diet & Exercise:** \_\_\_\_\_

**PHYSICIAN'S COMMENTS**

I believe that this student is physically qualified to pursue a full academic and sports program at The Greenwood School, with the exceptions of any limitations listed below:

Does this student have any health conditions that should be monitored at school? If yes, explain:

Please explain any special conditions and how should they be managed at school:

**Medication taken while at school:**

<i>Drug</i>	<i>Dose</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

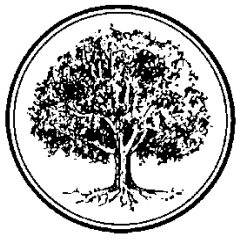
**Other:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_, M.D.

Date: \_\_\_\_\_



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## PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medication

\_\_\_\_\_  
Dose

\_\_\_\_\_  
Frequency

Beginning Date: \_\_\_\_\_

Last Dose: \_\_\_\_\_

Reason for Giving:

Special Instructions:

Other Medications and Dose being taken by student – *Please List All Meds*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Licensed Prescriber

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Prescriber

\_\_\_\_\_  
Phone Number of Prescriber

.....  
I hereby give permission for the above named student to take the medication as prescribed above and approve current medication schedule as stated. It is understood by me that the school is rendering a service by dispensing medication as prescribed by my physician and does not assume any responsibility for prescribed medication or its affects.

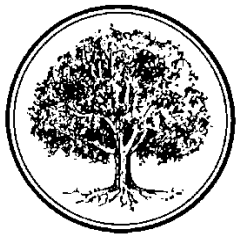
\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**NO MEDICATION WILL BE GIVEN AT SCHOOL UNTIL THE SCHOOL RECEIVES THIS COMPLETED FORM, WITH SIGNATURES, and prescribed medication in a container appropriately labeled by the pharmacy or licensed prescriber. Any changes in medications require this form with a signature from the prescribing MD.**

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Signature of School Nurse



# The Greenwood School

2011/2012 School Year

14 Greenwood Lane, Putney, Vermont 05346

Phone: 802-387-4545 • Fax: 802-387-5396



## Parent/Athlete Concussion Information Sheet

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

### WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

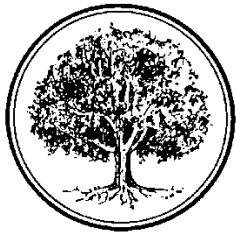
If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to

#### Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or “pressure” in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness ( <i>even briefly</i> )	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can't recall events <i>prior</i> to hit or fall	Confusion
Can't recall events <i>after</i> hit or fall	Just not “feeling right” or “feeling down”



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## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

### *Remember*

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

It's better to miss one game than the whole season. For more information on concussions, visit: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).

\_\_\_\_\_  
Student-Athlete Name Printed

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Printed

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date