



The MacDuffie School

Excellence in Education since 1890

One Ames Hill Drive
Springfield, MA 01105

(413) 734-4971 ext. 127

(413) 788-5778 fax Attn: School Nurse

www.macduffie.org

2009-2010 HEALTH AND MEDICAL SERVICES INFORMATION

To: Parents/Guardians of All Returning Students
From: The Guidance Office

The following are required annually of all students, Day and Ames Hill:

All are asked to return the enclosed forms before the opening of school:

1. **Authorization for Medications to be Taken During School Hours**
2. **Permission for Medical Treatment (included in Permission Forms packet)**
3. **Massachusetts School Health Record**
4. **Certificate of Immunization**

Returning students are asked to return the Certificate of Immunization which includes a subsequent evaluation by his/her physician. Returning students are obligated to inform the school of any additional immunizations (See enclosed letter regarding required immunizations).

Prescription Medicine Policy - all students requiring medication during the school day must present a written prescription from their physicians. In addition, the medications must be in the original prescription containers.

Note: the Prescription Medication Form must be returned to the School

Students requiring prescription medication during the school day should bring a daily dosage to the Guidance Office immediately upon arrival at school in the morning. All medications are taken under adult supervision in the Guidance Office by the students.

For the Ames Hill Students:

The school has an arrangement with Urgent Care Physicians by which ill boarding students can be seen by a doctor. (These doctors do not, however, perform routine physical examinations or administer immunizations. Both should be attended to before the student arrives at the school.) Emergency treatment can be arranged at one of the local hospitals. Baystate Medical Center and Mercy Hospital are both within five miles of the school.



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IMMUNIZATIONS -- 2009-2010

To: Physicians and Parents/Guardians of **Returning Students**

From: The Guidance Office

The Commonwealth of Massachusetts, Department of Public Health, requires that all students be immunized against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, varicella and hepatitis B. The only acceptable evidence of immunization is a physician's certificate: a form or letter signed and dated by the physician which specifies the month and year of administration and the type/name of the vaccine administered to the student. (See Massachusetts School Health Record which is enclosed.)

1. **Measles/Mumps/Rubella** - (MMR) Triviral Vaccine
grade 6 - 12: two doses, at least one month apart after 12 months of age
(The only exception is presentation of laboratory evidence of immunity.)
(Please note: **All seventh graders** must present proof of the additional dose of MMR. The physician may send the document directly to the school.)
2. **Diphtheria, Pertussis, Tetanus** - (DPT)
grades 6 - 12: five doses of DPT/DT or TD unless the fourth dose was given on or after the fourth birthday
booster of TD is required every 5 years if the last DPT/DT was given at or after five years since their last dose and the age of the child is 11-12
3. **Trivalent Oral Polio Vaccine** - (TOPV)
grades 6 - 12: at least four doses of oral polio vaccine required unless the dose is given on or after the fourth birthday
4. **Chicken Pox** (Varicella or Varivax Vaccine)
grade 7: 1 or 2 doses, **all seventh graders** must be vaccinated against chicken pox or present evidence of immunity (The immunization consists of one dose if given before age 13 or two doses if given after age 13)
5. **Hepatitis B**
grades 6 - 12: 3 doses required

ACCORDING TO STATE LAW, NO STUDENT IS ALLOWED TO ATTEND CLASSES WITHOUT THESE IMMUNIZATIONS. PLEASE BE SURE THE DOCUMENTATION HAS BEEN RETURNED TO THE SCHOOL BY OPENING DAY.



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2009-2010

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS **(SEE REVERSE SIDE FOR OTC MEDICATION)**

Student Name: _____

(Last)

(First)

Grade: _____ Sex: _____ Date of Birth: _____

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

Signature of Parent/Guardian

Date

Home Phone Number

Emergency Phone Number

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): _____

Date to start: _____ Date to stop: _____

Can student medicate self: Yes No

If medication is to be given describe indications: _____

How soon can it be repeated: _____

List significant side effects: _____

Other information: _____

Physician/Nurse Practitioner Name: _____

Physician/Nurse Practitioner Signature: _____ Date: _____ (over)

AUTHORIZATION FOR OVER THE COUNTER MEDICATIONS TO BE GIVEN BY
SCHOOL NURSE DURING SCHOOL HOURS

Please check if it is OK to give during school hours

- Tylenol 325-650mg PO q 6hr prn for
 - headache
 - fever
 - menstrual cramps
 - pain

- Ibuprofen 200-400mg PO q 6hr prn for
 - headache
 - fever
 - menstrual cramps
 - pain

- Coughdrop – 1 lozenger PO q 1 hr prn for cough

- Throat lozenger – 1 lozenger PO q 1 hr prn for sore throat

- Benadryl 25-50mg PO q 6hr prn for
 - allergic reaction
 - itching

- Pepto Bismol tablet 1 PO chewed q 1hr or Maalox 1 tab chewed 1 PO chewed q 1hr for
 - nausea
 - heartburn
 - acid stomach

- bacitracin ointment 1 pkt to wound prn

Signature of parent/guardian: _____ Date: _____

Physicians signature: _____ Date: _____

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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

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):

Date of PPD: ____; Results: ____ mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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 12/14/04

MASSACHUSETTS SCHOOL HEALTH RECORD

School _____ Female Male Year of Graduation _____
 Name _____ Last _____ First _____ Middle _____ Primary Language Spoken (home) _____
 Street _____ City/Town, State, Zip Code _____ Place of Birth _____

Contact Information

Emergency Contact Information

(1) Parent/Guardian: Name & Mailing Address if different: _____		(2) Parent/Guardian: Name & Mailing Address if different: _____		(1) Emergency Contact: Name & Phone Number: _____		(2) Emergency Contact: Name & Phone Number: _____	
Phone Numbers				Phone Numbers			
Home _____		Home _____		Primary Care Provider: Name: _____		Dental Care Provider: Name: _____	
Work _____		Work _____		Phone Number: _____		Phone Number: _____	
Cell _____		Cell _____		Health Insurance: _____			
FAX _____		FAX _____		Allergies: _____			

Primary Custody (if not joint) _____

School District	Year	Grade	Age	Growth			Vision				Hearing				Postural	
				Ht.	Wt.	BMI	Preschool Certificate	Left Eye	Right Eye	Stereopsis	Left Ear	Right Ear	Pass	Refer		
		Pre K														
		K														
		1														
		2														
		3														
		4														
		5														
		6														
		7														
		8														
		9														
		10														
		11														
		12														

Special Testing Lead Date ____/____/____; result ____mm; Tuberculin 1. Date of PPD ____/____/____; result ____mm; 2. Date of PPD ____/____/____; result ____mm; Low risk (no PPD done)

*School District on Waiver in accordance with MGL c71,s57 indicated by * in 'Grade' column.
 • Immunizations: Please attach complete Massachusetts Immunization Certificate/record
 • Due to software differences, this form may be used as a template for other formats. (All information on this form must be included.)

CERTIFICATE OF IMMUNIZATION

Name: _____ Date of Birth: / / Sex: M F

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine	Date/Vaccine Type	Date/Vaccine Type	Vaccine	Date/Vaccine Type	Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		Rotavirus	1	
	2			2	
	3			3	
	4		Measles, Mumps, Rubella (MMR, MMRV)	1	
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	1			2	
	2		Varicella (Var, MMRV)	1	
	3			2	
	4		Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	6		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1
7			2		
1			3		
2			4		
3			5		
4			6		
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1	
	2			2	
	3		Hepatitis A (HepA, HepA-HepB)	1	
	4			2	
	5			Human Papillomavirus (HPV)	1
Pneumococcal Conjugate (PCV7)	1		2		
	2		3		
	3		Other:		
	4				

Serologic Proof 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
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof 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: _____