League School of Greater Boston
300 Boston Providence Turnpike
Walpole, MA 02032
508-850-3900

Medical Information Parent Notification
2018-2019

DATE: June 4, 2018

Dear Parents:

Enclosed is a packet of emergency and medical forms that need to be completed annually. They are due back July 9, 2018.

Your child is required to have an annual physical:

Physicals

1. Physicals are required before admission to League School. The enclosed physician's forms must note **vision, hearing and scoliosis screenings.**

2. **Physicals and scoliosis** exams must be done annually by the student's physician. Parents are required to return these completed forms annually at their child's IEP.

3. **Hearing** must be checked annually through age 9, once from age 12-14 and once from age 15-18. This must be done by the student's physician.

4. **Vision** will be checked annually through age 11, once from age 12-14 and once from age 15-18. This must be done by the student's physician.

5. **All students must have annual dental exams** by the dentist of their choice and submit documentation to the nurse that this requirement has been completed. This will help promote healthy oral hygiene and prevent decay. Please schedule a dentist appointment and notify us of the appointment date. If your child has seen a dentist in the past year, please forward to the School Nurse a copy of the dental examination as soon as possible.

6. **Immunizations** must be up-to-date, per D.P.H. Massachusetts school immunization requirements.

If your child has not had a physical in the last twelve months, we require that you make an appointment and notify us of the appointment date within one week of receiving this letter. If your child has had a recent physical, please return their Physical Examination Form immediately. You may have your child's Primary Care Physician fax a copy of the physical directly to Jim Connolly or Anne Maxon Fax at 1-508-660-1895.

All students that have their medication administered during the day at school require a signed physician's order and completed parental permission form which is included in this package. Without this, the medication is not given. All medication orders expire at the end of the school year. New medication orders are needed for the start of a new school year, which begins July 9, 2018.

Please remember that these forms are required, and failure to return the emergency forms, signed physician's orders or have a current physical and immunizations on file may jeopardize your child's placement at the League School.

Thank you for your assistance. If you have any questions, please contact either one of us at 1-508-850-3900 ext. 134.

Sincerely,

Jim Connolly, RN or Anne Maxon, RN
School Nurse School Nurse

Enclosures

League School of Greater Boston
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Emergency Information Form
2018-2019

Student's Name: _____ DOB: _____

Mother's Name: _____

Mother's Address: _____

Home Phone: _____ Cell Phone: _____

Day Phone _____ E-mail: _____

Mother's Employment & Address: _____

Work Phone: _____ Days/Hour: _____

Father's Name: _____

Father's Address: _____

Home Phone: _____ Cell Phone: _____

Day Phone _____ E-mail: _____

Father's Employment & Address: _____

Work Phone: _____ Days/Hour: _____

Emergency Contacts (relative, neighbor, friend) other than Parents:

1. Name: _____ Relation: _____

   Address: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Name: _____ Relation: _____

   Address: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

Child's Medical Information:

Primary Care Physician: _____ Physician's Phone: _____ Fax #: _____

Specialists: _____ Specialist Phone: _____ Fax #: _____

Allergies: _____

Most recent tetanus booster: _____

Insurance Information:

Information concerning any private or state/federal medical or hospitalization coverage which may exist for the benefit of my child is listed below:

Name of Company: _____

Address: _____

Phone: _____ Policy Number: _____

Parent/Guardian Signature: _____ **Date:** _____

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Private Physician's Examination

2018-2019

Patient's Name: _____ Birth date: _____

Medical History (given dates)

Accidents		Encephalitis		Meningitis		Tonsillitis	
Allergy		Rubella		Mumps		Tuberculosis	
Asthma		Hearing		Operations		Vision	
Chicken Pox		Hearth Disease		Poliomyelitis		Whooping Cough	
Convulsions		Hernia		Rheumatic Fever		Other	
Diabetes		Kidney Disease		Scarlet Fever			
Ear Infections		Measles		Strep Throat			

Date of last complete physical exam: _____ Height: _____ Weight: _____

Significant Findings:

Blood Pressure: _____/_____ Hearing Screen: _____

Vision Screen: _____

Other Lab: _____

Scoliosis Screen: _____

TB Test: _____

Significant illness or injuries since last report:

General estimation of health:

Restrictions on sports participation or recommended modifications to school program:

Other Comments:

Signature (Examining Physician/Nurse Practitioner): _____ **Date:** _____

Name: _____

Phone Number: _____
(Please print)

Address: _____
(Please print)

(Form 2)

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CERTIFICATION OF IMMUNIZATION
2018-2019

Name: _____ Date of Birth: _____

Sex: ☐ Female ☐ Male

Vaccine					Date
Hepatitis				1	
				2	
				3	
DTaP	DTP	DT	Td		
				1	
				2	
				3	
				4	
				5	
IPV		OPV			
				1	
				2	
				3	
				4	
Required for ALL newly enrolled Full-Time residential students at public & private residential schools:					
Other: 1 dose of meningococcal polysaccharide vaccine (MPSV4) within the last 5 years (or a dose of meningococcal conjugate vaccine(MCV4) at anytime in the past					

Vaccine		Date
Hib	1	
	2	
	3	
	4	
MMR	1	
	2	
Varicella	1	
	2	

Chickenpox History

☐ Check this box if this person has a reliable History of chickenpox

Reliable history may be based on:

- Interpretation of parent/guardian's Description of condition.
- Physical examination, or
- Laboratory evidence

I certify that this immunization information was transferred from the above-named individuals' medical records:

Doctor or nurse's name: (please print) _____

Signature: _____ **Date:** _____

Facility name: _____

(Form 3)

2018-2019

DENTAL, HEARING AND VISION EXAMS

ALL STUDENTS MUST SUBMIT ANNUAL PHYSICAL EXAMS AS WELL AS UP TO DATE IMMUNIZATION RECORDS TO THE SCHOOL NURSE

Date of last Physical Exam: _____

All students must have annual dental exams by the dentist of their choice and submit documentation to the nurse that this requirement has been completed. This will help promote healthy oral hygiene and prevent decay. Please schedule a dentist appointment and notify us of the appointment date. If your child has seen a dentist in the past year, please forward to the School Nurse a copy of the dental examination as soon as possible.

Date of last Dental exam: _____
Please provide documentation from Dentist Office

Hearing must be checked annually through age 9, once from age 12-14 and once from age 15-18. This must be done by the student's physician.

Date of last Hearing exam: _____
Please provide documentation of the hearing exam if not already noted on physical form

Vision will be checked annually through age 11, once from age 12-14 and once from age 15-18. This must be done by the student's physician.

Date of last Vision exam: _____
Please provide documentation from Optometrist if seen by one

Student Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Jim Connolly, RN
jconnolly@leagueschool.com
Fax: 508-660-1895
Phone: 508-850-3900 ext. 134

Anne Maxon, RN
amaxon@leagueschool.com
Fax: 508-660-1895
Phone: 508-850-3900 ext. 134

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PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

2018-2019

Student: _____ /_/ Male /_/Female DOB: _____

My son/daughter is known to have the following allergies:

_____

_____

1. The school nurse and /or designated trained staff are authorized to administer medication to my child that is prescribed by his/her physician. I also give permission for the nurse and/or designated trained staff to administer general first aid treatment to my child, including non-prescription medication, insect repellant and sunscreen, for any mild discomfort associated with colds, upset stomach, cuts, etc.

2. I give permission to the school nurse to share information with appropriate school personnel relative to the prescribed medicine administration as she/he determines necessary for my child's health and safety.

3. I understand that the school nurse is NOT present for external community trips. If medication is scheduled for administration during a trip it will be administered by delegated program staff trained by the school nurse.

4. I understand that I may retrieve the medications from school at any time. Any discontinued medication will be destroyed if not picked up within one week.

5. I understand that I am responsible to deliver my child's medication(s) to school or to designate a responsible adult to deliver the medications to the school in a pharmacy or manufacturer labeled container. No more than a thirty day supply of the medication should be delivered to the school at any time. Students are not allowed to transport medications to school.

6. I understand if my child is a residential student, League School requires me to use Sullivan's Healthcare Parata pill packages with name, date, day, time and color coding. They are automatically scheduled for delivery to the school. **Medications that are not packaged by the pharmacy are not to be given by residential staff.**

7. I understand the Physician Medication Order (Form 3) must be completed by my child's licensed prescriber. This form must be renewed as needed and accompany this consent form.

Parent/Guardian Signature: _____ **Date:** _____

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League School Release Form
2018-2019

Please initial all statements below which confirm an understanding that the following conditions/parameters will apply to your child while enrolled to League School of Greater Boston:

_____ a. In case of emergency, and in my absence, League School is authorized to have my child taken to the nearest emergency room for medical care deemed necessary by the attending physician. I understand that I am responsible for costs of such treatment and transportation that may be incurred.

_____ b. League School may take, publish and exhibit photographs or videos of my child. In all instances, reasonable care will be taken so that no photograph of the student will represent the child in an unfavorable manner.

_____ c. League School may allow visitors to observe my child's classroom. These visitors will primarily be students in training for various professions dealing with children with developmental disabilities.

_____ d. League School is hereby authorized to transport my child in a fleet vehicle driven by school staff to participate in offsite school related activities.

Please sign and date below to acknowledge these notices.

Child's Name: _____

Parent/Guardian: _____

Date: _____

Parent/Guardian: _____

Date: _____

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Behavior Management Consent
2018-2019

I hereby give consent to the staff of League School of Greater Boston to use those behavioral management techniques for my child, _____, as they deem necessary and appropriate.

I understand that these techniques may include such practices as physical restraint (i.e. the teacher/s may bodily hold my child's hands, arms, legs, feet and/or head to prevent my child from injuring himself or others) and time out (excluding the child from the classroom for a period of time for disruptive or otherwise unacceptable behavior). Time out may be in a supervised Time Out room.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

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Physician Medication Order Form
2018-2019

This form is to be completed by Licensed Prescriber (Physician, Nurse Practitioner or others authorized by Chapter 94C) for medications that students will be receiving at school. League School of Greater Boston, Inc. must have a minimum of 30 days' supply of any medication your child is taking while at school.

Name of Student: _____ DOB: _____

Address: _____
Street City/Town State Zip

Name of Licensed Prescriber: _____

Address: _____

Business Phone: _____ **ALLERGIES:** _____

Business Fax: _____

Emergency Phone: _____

League School requires a prescription form for each medication administered at school.

Medication: _____

Route of Administration: _____

Dosage: _____ Frequency _____

Time (s) of Administration _____

Refills: _____ **Quantity** _____

Medication: _____

Route of Administration: _____

Dosage: _____ Frequency _____

Time (s) of Administration _____

Refills: _____ **Quantity:** _____

Medication: _____

Route of Administration: _____

Dosage: _____ Frequency _____

Time (s) of Administration _____

Refills: _____ **Quantity** _____

Medication: _____

Route of Administration: _____

Dosage: _____ Frequency _____

Time (s) of Administration _____

Refills: _____ **Quantity:** _____

Any other medications being taken by Student:

_____

_____
Signature of Licensed Prescriber

_____
Date

THE LEAGUE SCHOOL

School Year 2018-2019

MEDICAL EXEMPTION TO IMMUNIZATION

MASSACHUSETTS GENERAL LAW chapter 76, section 15 permits immunizations based on physician documentation of medical contraindication.

To be completed by physician

I, the physician of _____ have personally examined this child. In my opinion, the following immunization(s) is medically contraindicated at this time:_____

_____

The physical condition of this child is such that his/her health would be endangered by the vaccine(s).

Renew Annually_____ Permanent exemption_____

Signature:_____ Date:_____

Printed name:_____

Address:_____

Tel #:_____

To be completed by parent/guardian

I, the parent or guardian of _____, seeks medical exemption of behalf of my child for the following immunizations:_____

I understand that if there is a vaccine preventable outbreak of a disease for which my child has not been fully immunized, I will be notified by the school and my child MUST be excluded from school for the duration of the outbreak, according to Mass Department of Public Health regulations. Further, if the reason for exemption ceases to exist, my child will be required to be immunized at that time.

Parent signature_____ Date_____

To be completed by the Nurse

_____filed in student health record, to be reviewed at the beginning of each school year

_____Consulted with School Physician

_____Referred to Ma Department of Public Health on (date) _____

(Form 9A)

LEAGUE SCHOOL OR GREATER BOSTON

REQUEST FOR EXEMPTION FROM IMMUNIZATION

SCHOOL YEAR 2018-2019

Re: _____

As a parent (or guardian) having control of and responsibility for _____,

A minor enrolled in the League School or Greater Boston, I request that said minor be exempt from the vaccination and immunization requirements on religious grounds in accordance with the provisions of Chapter 285 of Acts of 1971.

Parent/ guardian signature: _____

Address:

_____

_____

Date: _____

Part of an act further regulating vaccination and immunization of school/camp children: Section 15 of Chapter 765 of the General Laws, as most recently amended by Chapter 590 of the Acts of 1967, is hereby amended... "**In the absence of an emergency or epidemic of disease declared by the Department of Public Health, no child whose parent or guardian states in writing that vaccination or immunization conflicts with his sincere religious beliefs shall be required to present said physician's certificate in order to be admitted to school.**" Chapter 285, Acts of 1971

Or

"**If a camper or staff member has religious objections to physical examinations or immunizations, the camper or staff member shall submit a written statement, signed by a parent or legal guardian of the camper, to the effect that the individual is in good health and stating the reason for such objections.**" 430.155

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MEDICATION LIST 2018-2019

Please provide a current list of medications for your child, even if they do not receive medications at school. Thank you.

Name of Student: _____ DOB: _____

Allergies _____

Name of medication: _____ Date started: _____

Dosage: _____

Frequency _____

Prescribing Physician _____

Name of medication: _____ Date started: _____

Dosage: _____

Frequency _____

Prescribing Physician _____

Name of medication: _____ Date started: _____

Dosage: _____

Frequency _____

Prescribing Physician _____

Name of medication: _____ Date started: _____

Dosage: _____

Frequency _____

Prescribing Physician _____

Name of medication: _____ Date started: _____

Dosage: _____

Frequency _____

Prescribing Physician _____

Name of medication: _____ Date started: _____

Dosage: _____

Frequency _____

Prescribing Physician _____

Parent/Guardian Signature: _____ **Date: :** _____