CATS ACADEMY BOSTON MEDICAL CHECK LIST

To be compliant with Massachusetts State Law we are required as a school to ask for the following contact and medical information. Some of these forms will need to be completed by you and some by your child's doctor at home before they arrive at school and each summer before they return each year.

We will need these forms returned prior to their arrival at school as we may not be legally allowed to have them join their classes without them.

TO BE COMPLETED BY PARENTS / GUARDIANS		COMPLETED
Contact Form	Contact and Medical Information	☐
Form A	Authorization for administration of over-the-counter medications	☐
Form B	Medication policy acknowledgement	☐
Form C	Authorization for medical treatment	☐
Form D	Meningococcal vaccination information & waiver	☐
Form E	Influenza vaccination information & consent	☐
TO BE COMPLETED BY YOUR DOCTOR / HEALTHCARE PROVIDER		**COMPLETED**
Form F	Massachusetts School Health Record	☐
Form G	Medication Order Sheet (Only if student takes prescription medication)	☐
Form H	Immunization record	☐
Form I	Varicella verification (Only for students without two doses of Varicella vaccine)	☐

CONTACT & STUDENT INFORMATION

Student Details	
First Name(s): [PRE-FILL]	Family Name: [PRE-FILL]
Preferred Name:	Student Email:
Cell Phone:	Home Phone:
US Cell Phone: (If applicable):	Native Language:
Main Contact / Parent / Guardian	
First Name(s):	Family Name:
Relationship to Student:	Email:
Cell Phone: (Inc +Intl code)	Nationality:
Parent / Guardian	
First Name(s):	Family Name:
Relationship to Student:	Email:
Cell Phone: (Inc +Intl code)	Nationality:

CONTACT & STUDENT INFORMATION *(CONTINUED)* EMERGENCY CONTACT INFORMATION	
We would like all students to have an appointed adult in the US who can be contacted in case of an emergency or circumstances requiring the student to leave the school campus urgently.	
First Name(s):	Family Name:
Relationship to Student:	Email:
Cell Phone: (Inc +Intl code)	Nationality:

CONTACT PREFERENCES

PLEASE INDICATE WHO YOU WOULD LIKE US TO CONTACT ABOUT THE FOLLOWING:

	Main Contact Parent / Guardian	Parent / Guardian	Agent
Invoicing & Fees	☐	☐	☐
Academic Report	☐	☐	☐
Parental Permission	☐	☐	☐
Post-Arrival Issues (Non-Medical)	☐	☐	☐

N.B. Medical issues can legally only be discussed with the students Parent/Guardian. If you would like us to discuss the student's medical issues with another party, please contact the school admissions office directly at JGwin@catsboston.com

STUDENT MEDICAL INFORMATION

					Yes	No
Does the student have a medical condition?					☐	☐
- If yes, please have your doctor complete form G						
Has the student ever been under the care of a mental health professional					☐	☐
- If yes, please specify:	Date:		Diagnosis:			
	Treatment:					

FORM A - AUTHORIZATION OF ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS

Student Name: _____Date of Birth: _____ Grade: _____

CATS Academy Boston's administrative policies, school physician collaboration and school nurse standards of practice allow us to administer to your child the following over the counter (non-prescription) medication including, but not limited to, acetaminophen (Tylenol), antacids (Tums), ibuprofen (Advil, Motrin), and cough drops in an over-the-counter, manufacturer's recommended dosage. These medications are supplied by CATS Academy Boston and kept by the nursing staff. To comply with the regulations of Massachusetts Law and the Board of Registration in Nursing, your written parental permission in REQUIRED for CATS Academy Boston to administer over-the-counter medications to your child. Please complete and return this form. No over-the-counter medication can be given without prior written parental authorization.

By signing below, I give permission for the School Nurse to administer over-the-counter medications to my child named above as the School Nurse determines appropriate for the child's health and safety. I authorize my child to self-carry and self-administer medication as determined appropriate by the School Nurse and as permitted by applicable law; the School Nurse may revoke this privilege if the student proves to be irresponsible or incapable. In my capacity as the custodial parent and/or appointed adult of the child, I hereby appoint CATS Academy Boston and the School Nurse my true and lawful representative for the purposes of taking all steps necessary to ensure the proper care of my child while my child is enrolled at CATS Academy Boston, and to execute any and all necessary documents and papers, including consent for treatment forms and consent to receive medical information from present and past providers, requested by any person or entity for treatment or rendering care to my child. In addition, the School Nurse and Finance office have permission to assist in the completion of medical claims and speak on my behalf regarding medical bills. I understand and agree that all bills rendered for medical expenses and travels to appointments are my responsibility to pay.

By signing below, I understand that CATS Academy Boston will generally maintain confidentiality with respect to my child's health information. I grant permission for health information related to my child to be given to my child's teachers, dorm parents, advisor, or any other employee of CATS Academy Boston when the School Nurse determines that providing such a person with the information is in the best interests of my child.

In order to receive updates regarding the health of my child, I grant permission to receive email updates addressed to the email address I have provided to CATS Academy Boston, kept on file with the Student Services department.

I, the undersigned, do hereby solemnly swear I have the legal custody of my child. I understand and acknowledge that my authorization and permission herein are valid for the duration of my child's time at CATS Academy Boston and can be withdrawn at any time. I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston, CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releasees"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releasees, which I or my child or heirs, legal representatives, successor, conservators and assigns may have, now or in future, which arises directly or indirectly by reason of exercise of the authorization granted above.

Print name of parent or appointed adult: _____

Signature of parent or appointed adult: _____ Date: _____

(If student is 18 years of age or older)

Print name of Student: _____

Signature of Student: _____ Date: _____

FORM B - MEDICATION POLICY ACKNOWLEDGEMENT

Student Name: _____Date of Birth: _____ Grade: _____

To help safeguard the health of the student, a Medication Order Form (or prescription), signed by the prescribing physician, must accompany all prescription medications. Any prescription for medication that is in a foreign language must be translated into English, evaluated by the CATS Academy Boston Health Services, and may need a follow up appointment with our school physician to determine a medication equivalent in the United States. It is required that for all students who are taking medication, a parent or appointed adult contact the School Nurse before the student's arrival to plan for the student's care and to schedule an appointment with a U.S. doctor if needed.

All medications must be checked in through Health Services by the above-named student's (the "student") parent or appointed adult. Medications not checked-in with Health Services will likely be considered contraband and may result in disciplinary action.

Students may be allowed to keep the following prescription medications in their dorm rooms after consulting with Health Services: Epi-Pens, inhalers, asthma allergy medications, birth control pills, acne treatments, and other medication that has been approved to be self-administered.

Prescription medications must be delivered in their original pharmacy or manufacturer labelled container by the student's parent or appointed adult. In extenuating circumstances, as determined by the School Nurse, the prescription medication may be delivered by other persons; provided, however, that the School Nurse is notified in advance by the parent or appointed adult of the arrangement and the quantity of prescription medication being delivered to CATS Academy Boston. Parents or appointed adults may retrieve the prescription medications from CATS Academy Boston at any time while CATS Academy Boston is in session and the student is enrolled at CATS Academy Boston.

Therefore, parents are expected to make arrangements to keep a supply of the student's prescription medications at home for the vacation breaks. Parents are responsible for re-supplying Health Services with the needed medications following the break. Students are not allowed to carry regulated, prescription medications to and from School unless they are authorized to self-administer such medication. If a student cannot transport the student's own medication and a parent/appointed adult cannot pick up the medication, CATS Academy Boston will destroy the medication one week after the last day of the spring semester.

Print name of parent or appointed adult: _____

Signature of parent or appointed adult: _____ Date: _____

(If student is 18 years of age or older)

Print name of Student: _____

Signature of Student: _____ Date: _____

FORM C – AUTHORIZATION FOR MEDICAL TREATMENT

Student Name: _____Date of Birth: _____ Grade: _____

In rare instances, a medical or dental, or any mental health emergencies requiring treatment arises in which written consent by parents or guardians is legally required, but the parents or guardians cannot be reached. In this event, and in order to avoid delay that might jeopardize the life or recovery of your child, we request the following permission from parents and guardians, with the understanding that efforts will be made to contact you in case of an emergency.

In my capacity as the custodial parent and/or legal guardian of the child, I hereby appoint CATS Academy Boston and the School Nurse my true and lawful representative for the purposes of taking all steps necessary to ensure the proper care (including medical, dental, surgical, psychiatric and hospital care) of my child while my child is enrolled at CATS Academy Boston, and to execute any and all necessary documents and papers, including consent for treatment forms, requested by any person or entity prior to treatment of or rendering of care to my child.

In authorizing such treatment, I agree to accept the determination of the treating physician, dentist, or other medical personnel that the treatment or examination rendered was medically necessary or advisable to protect the life, health or mental well-being of my child. Additionally, I hereby grant my authorization and consent for CATS Academy Boston and the School Nurse to administer general first aid treatment for any minor injuries or illnesses experienced by my child.

By signing below, I authorize CATS Academy and the CATS Academy School Nurse to permit commencement of medical treatment for my child when, in the professional judgment of physician, dentist, or other medical personnel involved, such treatment is medically necessary or advisable, even if I have not yet been consulted, specifically including, but not limited to:

- Obtaining medical treatment and procedures, including surgery and anesthesia, by appropriate health care providers, as needed
- Signing on my behalf for medical treatment, procedures, surgeries, anesthesia, etc.
- Releasing and obtaining relevant medical or mental health information from health care professionals providing treatment.
- Signing necessary consents and forms when I am not present.
- Obtaining routine medical treatment from appropriate health care providers if symptoms of illness occur (*e.g.,* fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).
- Obtaining immunizations, PPD tests and physical examinations as required by Massachusetts Law.
- Giving appropriate treatment for minor problems, such as cuts, bruises, sprains, headaches etc.
- Administering over the counter medications and prescription medications as needed.
- Requesting medical documentation from facilities regarding care given to my child; and/or
- Completing medical claims and speak on my behalf regarding medical bills.

I, the undersigned, do hereby solemnly swear that I have the legal custody of the child. I acknowledge that I have read this document in its entirety and I have satisfied myself that I understand the content of this agreement. By signing below, I authorize CATS Academy and the CATS Academy School Nurse to obtain medical treatment for my child and to permit commencement of medical treatment as described above. I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston, the CATS Academy Boston School Nurse, CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releasees"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releasees, which I or my child or our heirs, legal representatives, successors, conservators and assigns may have, now or in the future, which arise directly or indirectly by reason of exercise of the authority granted above.

Print name of parent or appointed adult: _____

Signature of parent or appointed adult: _____ Date: _____

(If student is 18 years of age or older)

Print name of Student: _____

Signature of Student: _____ Date: _____

FORM D – MENINGOCOCCAL VACCINATION INFORMATION & WAIVER FORM

INFORMATION ABOUT MENINGOCOCCAL DISEASE AND VACCINATION AND WAIVER FOR STUDENT AT RESIDENTIAL SCHOOLS AND COLLEGES

Massachusetts requires all newly enrolled full-time students attending a secondary school (e.g., boarding schools) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to:

1. receive quadrivalent meningococcal polysaccharide or conjugate vaccine to protect against serotypes A, C, W and Y; or
2. fall within one of the exemptions in the law, which are discussed on the reverse side of this sheet.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver at the end of this document. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

What is meningococcal disease?

Meningococcal disease is caused by infection with bacteria called *Neisseria meningitidis*. These bacteria can infect the tissue that surrounds the brain and spinal cord called the "meninges" and cause meningitis, or they can infect the blood or other body organs. In the US, about 1,000-1,200 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 11-19% lose their arms or legs, become hard of hearing or deaf, have problems with their nervous systems, including long term neurologic problems, or suffer seizures or strokes.

How is meningococcal disease spread?

These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person's saliva for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils, or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is most at risk for getting meningococcal disease?

High-risk groups include anyone with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited immune disorder), HIV infection, those traveling to countries where meningococcal disease is very common, microbiologists and people who may have been exposed to meningococcal disease during an outbreak. People who live in certain settings such as college freshmen living in dormitories and military recruits are also at greater risk of disease from some of the serogroups.

Are some students in college and secondary schools at risk for meningococcal disease?

College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease caused by some of the serotypes contained in the quadrivalent vaccine, as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving the exchange of saliva), may be what puts college students at a greater risk for infection. There is insufficient information about whether new students in other congregate living situations (e.g., residential schools) may also be at increased risk for meningococcal disease. But the similarity in their environments and some behaviors may increase their risk.

The risk of meningococcal disease for other college students, in particular older students and students who do not live-in congregate housing, is not increased. However, quadrivalent meningococcal vaccine is a safe and effective way to reduce their risk of contracting this disease. In general, the risk of invasive meningococcal B disease is not increased among college students relative to others of the same age not attending college. However, outbreaks of meningococcal B disease do occur, though rarely, at colleges and universities. Vaccination of students with meningococcal B vaccine may be recommended during outbreaks.

Is there a vaccine against meningococcal disease?

Yes, quadrivalent meningococcal polysaccharide vaccine (Menomune) and meningococcal conjugate vaccine (Menactra and Menveo) protect against 4 serotypes (subgroups), A, C, W, and Y of meningococcal disease. Meningococcal serogroup B vaccines (Bexsero and Trumenba) protect against serogroup B meningococcal disease. Currently, students are required to have a dose of quadrivalent polysaccharide vaccine within the last 5 years or a dose of quadrivalent conjugate vaccine at any time in the past (or fall within one of the exemptions allowed by law). Meningococcal serogroup B vaccines are not required for students in college or secondary schools and do not fulfill the requirement for receipt of meningococcal vaccine.

FORM D – (CONTINUED)

Please be aware that in October 2010 the Advisory Committee on Immunization Practices (ACIP) recommended booster doses of quadrivalent meningococcal conjugate vaccine for healthy adolescents 16-18 years of age. Persons up to 21 years of age entering college are recommended to have documentation of a dose of quadrivalent meningococcal conjugate vaccine no more than 5 years before enrollment, particularly if they are new residential students. Talk with your doctor about which meningococcal vaccines you should receive.

Is the meningococcal vaccine safe?

A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women.

Is it mandatory for students to receive meningococcal vaccine for entry into secondary schools or colleges that provide or license housing?

Massachusetts law (MGL Ch. 76, s.15D) requires newly enrolled full-time students attending a secondary school (those schools with grades 9-12) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to receive quadrivalent meningococcal vaccine. At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. All students covered by the regulations must provide documentation of having received a dose of quadrivalent meningococcal polysaccharide vaccine within the last 5 years (or a dose of quadrivalent meningococcal conjugate vaccine at any time in the past), unless they qualify for one of the exemptions allowed by the law. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; 2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine.

Where can a student get vaccinated?

Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of these vaccines. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?

- Your healthcare provider
- The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph/imm and www.mass.gov/dph/epi
- Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of quadrivalent meningococcal vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools, colleges and universities who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school or postsecondary institution to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

□ After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Student Name: _____ Date of Birth: _____

Student ID or SSN: _____

Signature: _____ Date: _____
(Student or parent/legal guardian if student is under 18 years of age)

Provided by the Massachusetts Department of Public Health / Division of Epidemiology and Immunization / 617-983-6800
MDPH Meningococcal Information and Waiver Form
Updated November 2015

FORM E – INFLUENZA VACCINE CONSENT

Student Name: _____Date of Birth: _____ Grade: _____

I give permission for my child to receive the influenza vaccine. The influenza vaccine may be administered via injection (inactive injectable influenza) or intranasal (live, attenuated influenza vaccine, LAIV). I have read the Influenza Vaccine Information sheets attached to this form, and am aware of the risks and potential side effects of the vaccine. I am aware that there is an additional cost for the influenza vaccine and that it will be billed to my child's student account.

I, the undersigned, do hereby solemnly swear that I have the legal custody of my child. By signing below, I hereby forever release, acquit, discharge, indemnify, covenant to hold harmless and covenant not to sue CATS Academy Boston and CATS Academy Boston's current, former and future trustees, employees, representatives, agents, volunteers, all related to or associated with CATS Academy, (all collectively referred to herein as "Releases"), from any and all claims, suits, liabilities, actions and causes of action, including but not limited to, negligence of Releases, which I or my child or our heirs, legal representatives, successors, conservators and assigns may have, now or in the future, which arise directly or indirectly by reason of exercise of the authority granted above.

Print Name of Parent or Guardian #1: _____

Signature of Parent or Guardian #1: _____ Date: _____

Print Name of Parent or Guardian #2: _____

Signature of Parent/Guardian #2: _____ Date: _____

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

Office Use Only

42 U.S.C. § 300aa-26

FORM F - MASSACHUSETTS SCHOOL HEALTH RECORD

The school health program should encourage the performance of the physical examination required in 105 CMR 200.100 by the student's own physician, nurse practitioner or physician assistant whenever possible. Said healthcare provider shall record the results of the physical examination on health record forms approved by the Department of Public Health.

Each child needs to present to the school nurse documentation of a physical examination PRIOR to first school entry and at intervals of every three to four years thereafter.

If participating in competitive sports, physical exams are required ANNUALLY.

Please ask your healthcare provider to complete the form on the following page.

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*

FORM G - MEDICATION ORDER SHEET (THIS FORM IS NEEDED ONLY IF YOUR CHILD TAKES PRESCRIPTION MEDICATION. PLEASE COMPLETE IN ENGLISH)

Student Name: _____Date of Birth: _____ Grade: _____

Does the student have any allergies to medicine / food / other?	YES ☐	NO ☐
- If yes, please provide details:		

MEDICATION ORDER SHEET BELOW IS TO BE COMPLETED BY LICENSED PRESCRIBER ANNUALLY

MEDICAL DIAGNOSIS	MEDICATION NAME	DOSE	ROUTE	FREQUENCY/TIME	START DATE	END DATE

Please use the space below to include any further instructions or information regarding the medications listed above including, but not limited to special side effects, contraindications, or possible adverse reactions to be observed:

Name and Title of Licensed Prescriber (please print): _____
Prescribers Signature: _____ Date: _____
Prescriber's Business Phone (include country code if outside of the United States): _____
Prescriber's Emergency Phone (including country code if outside of the United States): _____

FORM H - IMMUNIZATION RECORD *(EXPLANATION)*

Immunization type			Required documentation		
Hepatitis B	3 doses	OR	Laboratory proof of immunity attached to immunization record		
DTap DTP DT Td	5 doses DTaP or DTP	OR	4 doses of DTap/DTP if fourth dose in on or after fourth birthday	OR	DT only acceptable with a letter stating a medical contraindication to DTap/DTP
Tdap	1 dose				
Polio	4 doses required	OR	3 doses accepted if third dose is given on or after the fourth birthday, and greater or equal to 6 months following the previous dose	OR	If 4 doses are given before age 4 a fifth dose is recommended
MMR	2 doses	OR	Two doses of Measles, Two doses of Mumps, and Two doses of Rubella	OR	Laboratory Immunity
Meningococca	1 dose MCV4	OR	1 dose of MPSY4 in the past 5 years	OR	Signed Meningococcal waiver
Varicella	2 doses	OR	Laboratory immunity	OR	Signed proof of documented illness.

No unimmunized student shall be admitted to, or be allowed to remain in, school unless they can satisfy these requirements:

a) A medical exemption is allowed if a health care provider submits documentation to school that an immunization is medically contraindicated (needs to be submitted annually); or

b) A religious exemption is allowed if a parent submits a signed statement to school stating that immunizations are contrary to his/her sincere religious beliefs. This statement only needs to be submitted once.

Please note that students who are not immunized (including those with medical and religious exemptions) may be subject to exclusion from school if there is exposure to certain communicable childhood diseases, as specified in I 05 CMR 300.200.

If a certain required immunization is not provided in your country please inform the School Nurse.

Please note that we also require annual PPD tests for international students. "Low Risk" is not considered acceptable documentation.

Required for ALL INTERNATIONAL students: Tuberculosis screening: PPD/Mantoux

If screening results are positive (10>mm), the student must have chest X-ray. Documentation must be signed by a healthcare provider before arrival to school. The results can be recorded on Form F.

Any students who have had BCG vaccine are NOT exempt from a yearly PPD/Mantoux.

FORM H – IMMUNIZATION RECORD *(CONTINUED)*

Student Name: _____Date of Birth: _____ Grade: _____

	Date: M/D/Y		Vaccine Type		Date: M/D/Y		Vaccine Type
Hepatitis B	1			Polio Specification of Vaccine Type Required Types: IPV OR OPV	1		
	2				2		
	3				3		
	4				4		
	5				5		
Hepatitis B Immunity Test	Date: M/D/Y		Results:		6		
					7		
Diphtheria, Tetanus, Pertussis Specification of Vaccine Type Required Types: DTP, DTaP, DT, Td,	Date: M/D/Y		Vaccine Type	Meningococcal MCV4 or MPSV4 Required within the last 5 years	Date: M/D/Y		Vaccine Type
	1				1		
	2				2		
	3				3		
	4			BCG Vaccine	Date: M/D/Y		Vaccine Type
	5				1		
	Date: M/D/Y		1 Tdap Required		2		
Tdap	1			PPD test REQUIRED FOR INTERNATIONAL STUDENTS	Date: M/D/Y		Result
MMR	Date: M/D/Y				1		
	1				If >10mm Chest X-ray is Required		
	2			Varicella	Date: M/D/Y		Vaccine Type
Measles	Date: M/D/Y				1		
	1				2		
	2			If Patient had the Varicella disease document date, or proof of Immunity below.			
Mumps	Date: M/D/Y			Varicella Disease:	Approximate Date: M/D/Y		
	1						
	2			Varicella Titer test	Date: M/D/Y		Results:
Rubella	Date: M/D/Y						
	1						
	2						

I certify that this immunization information was transferred from the above-named individual's medical records.
Physician, nurse practitioner or physician assistant:
Name:_____ Date: (M/D/Y) _____
Signature: _____
Facility name: _____

FORM I - VARICELLA VERIFICATION (THIS FORM IS ONLY NEEDED IF YOUR CHILD HAS NOT RECEIVED TWO VARICELLA VACCINES)

Student Name: _____Date of Birth: _____ Grade: _____

According to the Massachusetts Department of Public Health, all schools are required to provide a record of two doses of the Varicella Vaccine or a reliable history of the chicken pox disease. A reliable source is as follows:
"In the case of Varicella, upon presentation of laboratory evidence of immunity or a statement signed by a physician, nurse practitioner, or physician assistant that the student has a history of chickenpox disease" (CMR 105:220.500, C-4).
Documentation of prior Varicella illness can be provided by:

1) Serologic confirmation or Varicella Immunity attached to this form (Positive Varicella lgG result)
2) The below written statement signed by a physician, nurse practitioner, or physician assistant

"This is to verify that (Name of Student) __[PRE-FILL]_____ had Varicella disease (chicken pox) on approximately (Month/Day/Year) _____ _____and does not need the Varicella vaccine."

By signing the below, I acknowledge that the above statement is true.

Physician, nurse practitioner or physician assistant:
Name:_____ Date: (M/D/Y) _____
Signature: _____
Facility name: _____