

**TRINITY-PAWLING SCHOOL**  
700 Route 22  
Pawling, New York 12564

**NEW STUDENT HEALTH FORM**  
**HEALTH CENTER**  
(845) 855-4848 FAX: (845) 855-4851  
email: agreene@trinitypawling.org  
gbarker@trinitypawling.org

**Allergies:** \_\_\_\_\_  
**Last Tetanus Vaccine:** \_\_\_\_\_

**Student's name** \_\_\_\_\_ **Birth date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade entering:** \_\_\_\_\_  
last first month date year

**Home address** \_\_\_\_\_ **SS #** \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
street city state zip

**Student resides with:** Both parents \_\_\_\_\_ **Father** \_\_\_\_\_ **Mother** \_\_\_\_\_ **Other** \_\_\_\_\_ **Student's cell #** \_\_\_\_\_

**Father** \_\_\_\_\_  
last first

**Mother** \_\_\_\_\_  
last first

**Residence phone** (\_\_\_\_) \_\_\_\_\_

**Residence phone** (\_\_\_\_) \_\_\_\_\_

**Business phone** (\_\_\_\_) \_\_\_\_\_

**Business phone** (\_\_\_\_) \_\_\_\_\_

**Cell phone** (\_\_\_\_) \_\_\_\_\_

**Cell phone** (\_\_\_\_) \_\_\_\_\_

**Email** \_\_\_\_\_

**Email** \_\_\_\_\_

**REQUIRED:** *(Local responsible person (not a parent) to be reached in case of emergency if parent/guardian is unavailable.)*

**Guardian/Alternate** \_\_\_\_\_  
last first

**Phone number** (\_\_\_\_) \_\_\_\_\_

**Cell phone** (\_\_\_\_) \_\_\_\_\_

**PERMISSION FOR MEDICAL/SURGICAL TREATMENT** *(This section must be signed in order for your son to attend school)*

I authorize the administration (the "Administration") of Trinity-Pawling School (the "School") to arrange for medical care and treatment, including medications, immunizations, drug testing and diagnostic tests for injuries and illnesses that my son may suffer while attending the School (whether or not such injuries or illnesses occur on campus). I also agree to notify School health personnel of any medical conditions arising when my son is not at School. Also, in the event of an emergency in which a delay in treatment may result in an increased risk to the life or health of my son, I authorize Administration to arrange for physician, hospital and other required medical care which may be deemed necessary by the treating health care provider to minimize any such risk to my son, including, but not limited to, diagnostic tests, hospitalization and/or surgery. I understand that I am responsible for all medical and dental expenses associated with the treatment of my son. I consent to the provision of such medical care.

**Signature of parent/guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

Student's name \_\_\_\_\_

**CONSENT AND RELEASE FROM LIABILITY** *(This section to be completed by parent or legal guardian.)*

By signing below, I represent to Trinity-Pawling School, its agents, Trustees, officers and employees that I have carefully read the information included on the Student Health Form and acknowledge that all of the information contained herein is true and complete. I further agree to update Trinity-Pawling in writing if any of the medical information included in this form changes.

In return for permitting my son to attend Trinity-Pawling School, and for allowing my son to participate in school activities both on and off campus, including both required curricular and voluntary extracurricular activities, I hereby consent to the disclosure of my son's medical information as provided for in this form and I agree not to bring any claims or legal actions against Trinity-Pawling School, its agents, trustees, officers, and employees pertaining to or arising out of (i) disclosure of my son's medical information as provided in this form or (ii) any health care services provided by the school nurse or other Trinity-Pawling School employees in accordance with this Student Health Form, except in the case of gross negligence or willful misconduct. Without limiting the above, I agree not to sue for any matter relating to this paragraph based on claims for negligence, personal injury, breach of contract, breach of warranty, defamation or invasion of privacy.

I further understand that Trinity-Pawling School is not responsible for the medical services provided by independent contractor health professionals, such as the school physician and other physicians and hospitals who may provide medical services to my son.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

**SPORTS AUTHORIZATION** *(This section to be completed by parent or legal guardian.)*

Trinity-Pawling maintains a policy of compulsory athletics for all students as a means to ensure regular physical exercise and emphasize the importance of self-discipline and sportsmanship. All precautionary measures will be taken to safeguard our students during practices and games. However, in all types of physical competition, injuries might occur as a result of unavoidable accidents; even serious injuries and/or death. They cannot be foreseen. Fortunately, in the majority of cases, these injuries are of a comparatively minor nature. By signing below, I, as my child's parent/guardian, hereby give my permission for my child to participate in sports.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

**Privacy Policy** *(This section to be completed by parent or legal guardian.)*

By signing below, I represent to Trinity-Pawling School its agents, Trustees, Officers and employees that I have received and carefully read the notice of Privacy Practices of the School's Infirmary.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of student (if over 18) \_\_\_\_\_ Date \_\_\_\_\_

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Email: [agreene@trinitypawling.org](mailto:agreene@trinitypawling.org), [gbarker@trinitypawling.org](mailto:gbarker@trinitypawling.org)

**Student's name** \_\_\_\_\_

<i>Has the student ever had...</i>	<b>YES</b>	<b>NO</b>	<b>EXPLAIN EVERY YES ANSWER &amp; provide date of event.</b>
Mononucleosis			
Mumps			
Measles			
Chicken Pox			
German Measles			
TB			
Sexually Transmitted Disease			
Rheumatic Fever			
Cancer/Tumor			
Anxiety/Depression			
Weight Change/Eating Concerns			
Tobacco Use			
Alcohol or Other Drug Use			
Orthopedic Problems			
Thyroid/Hormone Problems			
Diabetes			
Skin Problems/Eczema			
Anemia/Blood Disorder			
Dental-Problems			
Eye,-Ear,-Nose/Throat Problems			
Pneumonia/Bronchitis/Sinusitis			
Allergies			
Anaphylactic Reaction to what:			
Epi Pen			
Allergy Injections			
Asthma/Wheezing			
Chest Pain/Shortness of Breath			
High Blood Pressure			
Heart Disease			
Intestinal/Digestive Problems			
Jaundice/Hepatitis			
Kidney-Disease/Bladder Infection			
Fractures/Sprains/Arthritis			
Back Problems			
Surgical Procedure			
Head Injury			
Severe Headaches			
Fainting/Loss of Consciousness			
Seizures			
Attention Deficit Disorder			
Counseling (specify for what)			
Other (please specify)			

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**TO THE PHYSICIAN:** Please review the student's history and complete the medical examination form.

**Student's name** \_\_\_\_\_

SYSTEM	NORMAL	DESCRIBE IF ABNORMAL	*REQUIRED*	
Skin				
Ears			*HT:	*BMI:
Eyes				
Nose, throat, teeth, gingival			*WT:	<input type="checkbox"/> less than 5th
Neck/thyroid				
Chest			*BP:	<input type="checkbox"/> 85 <sup>th</sup> thru 94 <sup>th</sup>
Lungs				
Heart			*P:	<input type="checkbox"/> 95 <sup>th</sup> or higher
Abdomen, liver, spleen, kidneys				
Hernia			*HEARING: Pass / Fail	
Genitourinary			Right:	Left:
Musculoskeletal (scoliosis)			Vision	
Lymphatic			Glasses	No Glasses
Neurological			Rt	Rt
Other			Lt	Lt

**TB:** In high risk group:  Yes  No **TB test results:** \_\_\_\_\_ **Date** \_\_\_\_\_

**If positive TB test, results of Chest X-ray:** \_\_\_\_\_ **Date** \_\_\_\_\_

**CHRONIC DISEASE ASSESSMENT:**

Yes No

Asthma  Mild  Severe

Diabetes  Type I  Type II

Anaphylactic Reaction To: \_\_\_\_\_

Seizure Disorder: Type \_\_\_\_\_

Cardiac Condition \_\_\_\_\_

Other (Please specify) \_\_\_\_\_

**MEDICATIONS** currently being taken \_\_\_\_\_

(Please complete a Medical Authorization Form for each medication ordered)

**ALLERGIES** \_\_\_\_\_

Type of reaction (rash, urticaria, anaphylaxis) \_\_\_\_\_

**SPORTS RESTRICTIONS** (ability to participate in sports)

\_\_\_ Unrestricted \_\_\_ Partial restrictions \_\_\_ Full restriction **Comment** \_\_\_\_\_

**PRINT:** Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Fax # \_\_\_\_\_

Examiner's signature \_\_\_\_\_ Date \_\_\_\_\_

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Student's name \_\_\_\_\_

Your child must meet New York State immunization requirements to enroll in school.

The following vaccines are **required** for your child to attend school:

- **3 doses of diphtheria**—containing toxoid (usually administered as DPT, DT, Td)
- **1 dose of Tdap for students born after 1/1/94**
- **3 doses of oral poliovirus vaccine (OPV)**
- **2 doses of measles vaccine**—the first administered after 15 months of age and the second after 4-6 years of age
- **1 dose of mumps vaccine** administered after 12 months of age
- **1 dose of rubella vaccine** administered after 12 months of age
- **1 dose of Varicella vaccine** administered after 12 months of age
- **3 doses of HepB series** for all students

*There are only two exceptions to the foregoing that are authorized.—One for reasons of health, the other because of religious beliefs. In such instances, either a statement from a physician is required indicating that the immunization is not indicated for reasons of health, or a written statement must be submitted by the parents or guardian of the child stating that the parent or guardian is a bona fide member of a special religious organization whose teachings prohibit administering an immunizing agent.*

DTP	*	*	*			
DTP/Hib						
Tdap	*			For students born after 1/1/94		
DT/Td						
OPV	*	*	*			
IPV						
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HiB						
Hep B	*	*	*			
Varicella	*			Required for students born after 1/1/94		
Meningococcal				One dose optional but strongly encouraged		
Other Vaccines (specify)						

Disease Hx of above \_\_\_\_\_

(Specify disease)

(Date)

(Confirmed by)

**Exemption:**

Religious \_\_\_\_\_ Medical: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ Date \_\_\_\_\_

**PRINT:**

Physician's name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Fax # \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

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### **INSURANCE INFORMATION for School Year 2011-2012**

Every student is required to have some form of comprehensive medical insurance. Please furnish us with the following information so that we may provide your son with the care that he deserves, in an expeditious manner. It is very important that this information be kept up to date. Therefore if you change insurance companies, please let us know. Please enclose a copy of the front & back of your son's insurance card and pharmacy card. Also, please give your son a card to carry. We will bill any pharmacy copay to your son's student account.

*Health care providers: Please call Mrs. Greene at (845) 855-4848  
if you have any questions regarding this student's care or insurance coverage.*

Student's name \_\_\_\_\_  
Student's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Student's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Student's phone # \_\_\_\_\_

Subscriber's name \_\_\_\_\_  
Subscriber's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Subscriber's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Subscriber's address \_\_\_\_\_  
Subscriber's phone # (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_  
Insurance company address \_\_\_\_\_

Insurance company phone # to call if we have questions regarding your coverage: (\_\_\_\_) \_\_\_\_\_  
ID # \_\_\_\_\_ Group# \_\_\_\_\_ Person Code \_\_\_\_\_

**Does your insurance company require referrals from your primary care physician?** Yes \_\_\_ No \_\_\_

**Have you enrolled in one of the insurance plans offered by Trinity-Pawling?**

Accident Insurance Yes \_\_\_\_\_ No \_\_\_\_\_  
Medical Insurance Yes \_\_\_\_\_ No \_\_\_\_\_

**PLEASE COPY FRONT AND BACK OF INSURANCE CARD AND  
SEND TO SCHOOL INFIRMARY**

### **PHARMACY INFORMATION**

Does your insurance company cover prescription medication? Yes \_\_\_ No \_\_\_

**Prescriptions are filled in the following manner:**

- 1) Any prescription ordered by your private physician must be filled at home and sent to T-P accompanied by a **written** authorization. Every change in medication must be authorized **in writing** by your physician.
- 2) Any prescription ordered by our physicians will be filled locally, unless our providers are unable to use your insurance.
- 3) We will bill any pharmacy co-payments to your son's student account.