

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

**RETURNING STUDENT HEALTH FORM
HEALTH FORM**

(845) 855-4848 FAX: (845) 855-4851

Email: agreene@trinitypawling.org
gbarker@trinitypawling.org

Allergies _____

Date of last Tetanus _____

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 # _____
(please specify)

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 _____

Phone number (____) _____
last first

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 _____

Trinity-Pawling School

700 Route 22

Pawling, NY 12564

845-855-4848 Fax#: 845-855-4851

Email: agreene@trinitypawling.org, gbarker@trinitypawling.org

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 _____

INTERVAL HEALTH HISTORY FOR RETURNING STUDENTS

1) Is your child currently taking medication? No Yes
(If yes, please list all medications and have your son's doctor complete the medication authorization from.)
If yes, please list: _____

2) Has your child been ill, sustained a concussion, injured, or undergone surgery or developed any new problems since his last physical?
 No Yes If yes, please list: _____

3) Has your child received any immunizations since his last physical?
 No Yes If yes, please list: _____

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 th thru 94 th
Lungs				
Heart			P:	<input type="checkbox"/> 95 th 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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HEALTH CENTER
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email: agreene@trinitypawling.org
gbarker@trinitypawling.org

INSURANCE INFORMATION

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 _____

Subscriber's name _____

Student's SS# ____/____/____

Subscriber's SS# ____/____/____

Student's date of birth ____/____/____

Subscriber's date of birth ____/____/____

Student's phone # _____

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.