

Date of last tetanus: \_\_\_\_\_ Last TB \_\_\_\_\_

Allergies: \_\_\_\_\_

Significant Medical Problems: \_\_\_\_\_

DUNN SCHOOL

PO Box 98

Los Olivos, CA 93441

(805) 688-6471

Nurse's Fax: (805) 688-3421

## AUTHORIZATION FOR TREATMENT FORM

This form constitutes a permission statement which must be signed by a parent or guardian. The completed form must be returned to the Dunn School health office. This health record is to be completed by the parent or guardian. **Please complete the entire form! (PLEASE PRINT)**

Student Name: \_\_\_\_\_ Entering Grade: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_\_ Male/Female Student resides with: Both Parents/ Mother / Father / Other  
(Circle one) (Circle one)

Mother:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Cell: \_\_\_\_\_

Father:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Cell: \_\_\_\_\_

**In Case Parent cannot be reached:**  
Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Cell: \_\_\_\_\_

**Person Responsible for medical expenses:**  
Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Cell: \_\_\_\_\_

### Authorization to consent to treatment of a minor

I, We, the parent(s)/guardian of \_\_\_\_\_, a minor, do hereby authorize any Dunn School personnel in Los Olivos, CA as agents of the undersigned to consent to any x-ray examination, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at a hospital. The authorization also applies to dental care under a duly licensed dentist and psychological care.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) or any organization involved including without limitation the Dunn School. Dunn School will not assume any financial responsibility for exercising this action.

This authorization is given and shall remain effective until revoked in writing and delivered to said agent(s).

\_\_\_\_\_  
Signature of parent(s) or legal guardian of the student named above Date: \_\_\_\_\_



## **EMERGENCY RELEASE AUTHORIZATION**

**In the event of a catastrophic emergency, that requires the closure of the school and dismissal of the student body, Dunn School may release my daughter/son, \_\_\_\_\_, to an authorized person listed below:**

1) NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2) NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

3) NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_  
**(SIGNATURE OF PARENT OR GUARDIAN)** **Date** \_\_\_\_\_

# PROOF OF INSURANCE

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## COPY BOTH SIDES OF INSURANCE CARD

Be sure all information is legible. If you change insurance during the year, you must send a legible copy of both sides to the Nurse's office as soon as possible. If you have separate insurance plans for dental car and/or prescriptions, please include copies of those cards.

*Please make certain your student's medical and dental insurance is accepted in the State of California, preferably in the location of the school.*

**Note to International Students:  
(If you are an international student who receives insurance through  
Dunn School, there is no need to send a copy of your card.)**



Student Name: \_\_\_\_\_

**MEDICATIONS:**  
**To be filled out by Physician**

**Standard Medication Distribution Times:**

**Breakfast:** 7:00 AM  
**Dinner:** 6:00 PM  
**Bedtime:** 10:00 PM

**Weekend Medication Distribution:**

**Brunch:** 9:00 - 11:00 AM  
**Dinner:** 6:00 PM  
**Bedtime:** 10:00 PM

*Students requiring medication distributions at time other than above will be required to pick up those medications at the Nurse's Office. Please note: Nurse's Office is open at specific times from 7:30 a.m. - 4:00 p.m., Monday - Friday only. Lunchtime meds are available in the nursing office Monday - Friday only.*

**Current Medications:**

*Please include any vitamins, supplements, and over-the-counter medications.*

Medication	Strength	Dose	Diagnosis	Times to be given
				7:00 AM 6:00 PM 10:00 PM
				7:00 AM 6:00 PM 10:00 PM
				7:00 AM 6:00 PM 10:00 PM
				7:00 AM 6:00 PM 10:00 PM
				7:00 AM 6:00 PM 10:00 PM
				7:00 AM 6:00 PM 10:00 PM

**Medications to be taken as needed:**

Medication	Strength	Dose	Diagnosis	Frequency

Due to problems encountered in the past, we request prescriptions to be refilled at Star Drugs in Santa Ynez, CA.  
Phone: 805-688-6898 - FAX: 805-688-6047

**Part 2: To be completed by attending physician:**

The child named above is under my care. It is necessary for him/her to receive the medications listed on this page on a regular/emergency basis.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Student: \_\_\_\_\_ Date: \_\_\_\_\_

## STUDENT IMMUNIZATION RECORD TO BE COMPLETED BY PARENT

**Tetanus:** Date of last shot: \_\_\_\_\_  
(Must be within the last 10 years)

**\*Tuberculosis:** Date of last skin test: \_\_\_\_\_  
(It is **mandatory** it be within the last 2 years, or 1 year if the student has traveled anywhere out of the country within the last 12 months.)

**Type Given:** PPD-Mantoux: \_\_\_\_\_ Other: \_\_\_\_\_

**Results:** Positive: \_\_\_\_\_ Negative: \_\_\_\_\_

**Date of chest X-Ray:** \_\_\_\_\_ **Impression:** \_\_\_\_\_ **Results:** \_\_\_\_\_

**BCG:** \_\_\_\_\_

<b>DTP:</b>	_____	_____	_____	_____	_____
<b>DT:</b>	_____	_____	_____	_____	_____
<b>TD:</b>	_____	_____	_____	_____	_____
<b>Polio:</b>	_____	_____	_____	_____	_____
<b>MMR:</b>	_____	_____	_____	_____	_____
<b>Measles:</b>	_____	_____	_____	_____	_____
<b>Mumps:</b>	_____	_____	_____	_____	_____
<b>Rubella:</b>	_____	_____	_____	_____	_____
<b>Hib:</b>	_____	_____	_____	_____	_____
<b>Hep. A:</b>	_____	_____	_____	_____	_____
<b>Hep. B:</b>	_____	_____	_____	_____	_____
<b>Varicella:</b>	_____	_____	_____	_____	_____

**Others:** \_\_\_\_\_  
\_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICATION AUTHORIZATION

Student: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS.

Educational Code 49423 and 49423.5. Any pupil who is required to take prescribed medication by a physician may be assisted by the school nurse or other designated school personnel if the school receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school assist the pupil in the matters set forth in the physician's statement. **CAC Title 5, 18170.**

## HAVE PHARMACY OR PHYSICIAN PROPERLY LABEL MEDICATION IN A SEALED CONTAINER FOR SCHOOL ADMINISTRATION.

### ***PART 1: Required - to be completed by parent or guardian***

I request that designated personnel assist my child in taking the medication prescribed by a physician. I understand that my child **may not** have or take medication at school unless **all** requirements are met. I also request that my child be assisted in taking over-the-counter medications, vitamins and nutritional supplements. The type of medication will be determined by the symptoms presented by the student. I hereby give consent for the school nurse to communicate with my physician as needed with regard to these medications. **All medications, vitamins, supplements, etc. must be distributed through the Nursing Office. No medication (prescription or over-the-counter) vitamin, supplement, or herbal supplement may be kept by the student in their room. Exceptions are, asthma medication, and some dermatological creams. These must be presented to the Nurse and will be labeled and returned to the student. Any unauthorized items found in the student's room could lead to disciplinary action. If mailing, please address all medications, vitamins, supplements, etc, to the attention of the School Nurse, *not your student.***

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Physician's Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Student: \_\_\_\_\_ Date completed: \_\_\_\_\_

# MEDICAL HISTORY

To be completed by parent or guardian.  
Please give this form careful thought and fill out entirely.

Is your child known to be resistant to any antibiotics? \_\_\_\_\_

Allergies to:

Drugs: \_\_\_\_\_ Food: \_\_\_\_\_ Seasonal Allergies: \_\_\_\_\_

Has student received any counseling or psychological care? Yes: \_\_\_\_\_ No: \_\_\_\_\_ When? \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Orthodontia in progress? \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_ Prescription glasses: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Contacts? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Please enclose copy of lens prescription** (students required to wear glasses for sports must have glasses which comply with ANSI Z 87.1 standard, or they will not be allowed to participate.

Are you a vegetarian? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Vegan? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Any dietary restrictions? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Explain dietary restrictions: \_\_\_\_\_

Please provide names, ages, and state of health of family member's

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Brother: \_\_\_\_\_ Sister: \_\_\_\_\_

Serious illnesses or diseases occurring in family (such as TB, diabetes, heart diseases, kidney, cancer, stroke, high blood pressure: \_\_\_\_\_

Important occurrences and dates in family: Deaths: \_\_\_\_\_

Divorce: \_\_\_\_\_ Adoption: \_\_\_\_\_ Other: \_\_\_\_\_

**Does your child have now or has he/she ever had any of the following? Please check the items that apply and comment below.**

<input type="checkbox"/>	Measles	<input type="checkbox"/>	Trouble Sleeping	<input type="checkbox"/>	Gastro-Intestinal Problems
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	Eating Disorders
<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Deformities
<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Serious Injuries
<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Motion Sickness	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	Bone/Joint Problems
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Sinusitis/Bronchitis	<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	Foot Problems
<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	Operations/Serious Injuries
<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Orthodontia	<input type="checkbox"/>	Sexually Transmitted Diseases
<input type="checkbox"/>	Polio	<input type="checkbox"/>	Gum/Tooth Problems	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	Painful Urination/UTI
<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Learning Disorder	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	Depression./Anxiety	<input type="checkbox"/>	Nutritional Problems	<input type="checkbox"/>	Sleepwalking
<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Skin Problems

Comments: \_\_\_\_\_

Is there anything else about your child's health that we need to know? \_\_\_\_\_

Does your child have a history of tobacco use or drug abuse? \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Student: \_\_\_\_\_ Date: \_\_\_\_\_

## **FLU SHOT**

Dear Parents:

Flu immunizations will be administered on campus sometime this fall. This injection is highly recommended for students, age fourteen years and older, in a boarding school situation. The fee for the service is \$22.00 per person. This fee will be charged to the student's account.

Please indicate whether you want your child to receive this immunization, and sign and return this sheet with the other medical forms.

Thank you for your cooperation,

Dunn School Health Services

**This vaccine is NOT recommended for students with KNOWN ALLERGIES TO: CHICKENS, FEATHERS, or EGGS.**

### **Uncommon, but possible adverse reaction to the Flu Immunization:**

Fever, vague body aches, muscular pains and other systemic symptoms may occur during the first 6-12 hours after vaccination and may persist for one or two days.

Immediate, presumably allergic reaction such as flare and weal or respiratory problems may develop and are indicative of sensitivity to the components of the serum derived from residual egg protein. This type of response is extremely rare.

Neurological disorders, including encephalopathy and ascending paralysis, have been known to have a temporary association with the administration of the flu vaccine. These occur rarely and are usually self-limiting and reversible.

I, the parent/guardian of \_\_\_\_\_  
(student's name)

Give  Do not give  permission to have my child immunized against the flu.

Signed: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
(circle one)