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 (Circle one) Student resides with: Both Parents/ Mother / Father / Other (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).

____ Date:_________________________
Signature of parent(s) or legal guardian of the student named above

AUTHORIZATION FOR TREATMENT FORM

For Outdoor Education trips

(This form constitutes a permission statement which must be signed by a parent or guardian)

I, we, the parent(s)/guardian(s) of___________________________________,
(Name) (Date of Birth)

a minor, do hereby authorize any Dunn School personnel in Los Olivos, CA as agents of the undersigned to consent to any medical procedure or treatment which is deemed advisable by and rendered under the general or specialized 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 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 foresaid agent(s) or any organization involved including without limitation the Dunn School, assumes any responsibility for exercising this action.

___________________________________ _________________________
Signature of parent or legal guardian *Date*

___________________________________ _________________________
Signature of parent or legal guardian *Date*

Significant medical problems, illnesses or past surgeries:

____
____
____

ALLERGIES (please list medication, food, and seasonal allergies)

____
____
____

MEDICATIONS (please list medications that the student is on)

____
____
____

Contraindications on Medication

____
____

Must take Medication______________ Can Refuse Medication___________

Date of last tetanus?______________ Last TB test or chest X-ray_____________

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: ________________

____ **Date____________**

(SIGNATURE OF PARENT OR GUARDIAN)

PROOF OF INSURANCE

****

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.)

DUNN SCHOOL PHYSICAL

MUST BE FILLED OUT BY A MEDICAL PHYSICIAN

Students are required to have an annual physical exam. Doctor, please review this student's health history and complete this form. The information is used in the student health office and will be released in case of an emergency or if the student requires medical treatment.

PLEASE BE CERTAIN THE STUDENT'S IMMUNIZATIONS ARE UP TO DATE.

This school requires a PPD every 12 months if a student has traveled out of the country, and every two years if student has stayed in the country.

Student Name: ___________________________ Age: ___________ Grade: _________

Date of Birth: ___________ Male:___ Female: ____ Height: ______ Weight: _______

	Normal	Abnormal
Head, ears, nose, throat		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Genito-urinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
GYN Exam if sexually active		

Comments:

Allergies: ________________________
Drug Allergies: ___________________
Date of last PPD/CXR: ____________
Results of last PPD/CXR: __________
Blood Pressure: __/__ Heart Rate: ____
Dipstick Urinalysis: Sugar ____
Albumin: ________
Hemoglobin or Hematocrit: _________
Date of last Dental exam: __________
Date of last eye exam: _____________

Wears glasses/contacts/both/neither

Vision	Uncorrected	Corrected
OS		
OD		
OU		

Is student capable of physical activity and participation in a competitive sports program?
Yes: ______ No: _________ Explain: _______________________________

Any physical restrictions? Yes: ______ No: ______ Dietary Restrictions? Yes: ____ No: ____
Explain: ____

Has student received any counseling or psychological care? Yes: ____ No: ____ When: _____
Reason for treatment: ______________________ Is further treatment needed? ____________
Other significant medical history (e.g. surgeries, hospitalizations, serious injuries, pregnancies, sexually transmitted diseases): ____

Examining Physician (Please print): ____
Address: ____ Phone: ____________________
____

Physician's Signature: ____ Date: ___________

If you have any questions, please call the Dunn School Nursing Office at (805) 688-6471.

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)

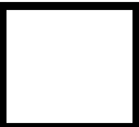
***Tuberculosis:** Date of last skin test: _______________
(It is **mandatory** it be within the last 2 years, or 1 year if the student has traveled anywhere out of the country within the last 12 months.)

Type Given: PPD-Mantoux: ________ Other: ________
Results: Positive: __________ Negative: __________
Date of chest X-Ray: _____________ Impression: ____________ Results: ____________
BCG: ______________

DTP: ____________ ____________ ____________ ____________ ____________
DT: ____________ ____________ ____________ ____________ ____________
TD: ____________ ____________ ____________

Polio: ____________ ____________ ____________ ____________ ____________
MMR: ____________ ____________
Measles: ____________ ____________
Mumps: ____________ ____________
Rubella: ____________ ____________
Hib: ____________ ____________ ____________ ____________
Hep. A: ____________ ____________ ____________
Hep. B: ____________ ____________ ____________
Varicella: ____________

Others: ____________ ____________
____________ ____________



By checking the box, I certify that there are no changes from the previous year.
***If tuberculosis is needed, you may check this box, but enter the date above in the proper area.**

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.

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