FAITH PREPARATORY SCHOOL • K-12
600 Danbury Road • New Milford, CT • 06776
860-210-3677 • Fax 860-210-3685

Frank Santora,
Pastor
Josephine DuBois,
Principal/Administrator

MEDICAL QUESTIONNAIRE, HEALTH EXAMINATION AND RELEASE FORM

This medical form must be filled in completely by the Parent/Guardian and Physician. Only medical exams performed within 12 months prior to the beginning of school may be referenced on this form. Student must have a medical examination within 12 months prior to the beginning of school.

Parts A, B, C, D, E, F, H and I to be completed and signed by Parent/Guardian.
Parts F and G to be completed and signed by the examining Physician.

Part A: Medical History

To be completed by Parent or Guardian Date: _____

Student Name: (Full Name on Passport**:** Last, First, MI):

_____

Name: _____
Circle One: Mother / Father / Guardian
Telephone #: _____

Name: _____
Circle One: Mother/ Father / Guardian
Telephone #: _____

Attending Physician's Name: _____

Telephone #: _____

Physician's Address:

_____
Street City Province/District Country ZIP

1. Please list any diseases, conditions, or illnesses that affect your child's daily life and describe:

_____
_____
_____
_____

2. Please list all operations, fractures, sprains, bone dislocations or breaks, or other medical interventions.

_____ Age: _____
_____ Age: _____
_____ Age: _____

3. Please list any known allergies. *If additional space is needed, please continue on back of page.*

_____ Circle one: Food / Drug / Other
_____ Circle one: Food / Drug / Other
_____ Circle one: Food / Drug / Other

4. Has your child ever been diagnosed with any of the following conditions?

Asthma/allergies	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Fainting/convulsions	☐ Yes ☐ No	Kidney injury	☐ Yes ☐ No
Heat stroke	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Head injury	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No
Heart murmurs	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heat exhaustion	☐ Yes ☐ No	Gum disease	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Insect allergy	☐ Yes ☐ No
Other heart condition	☐ Yes ☐ No	Blood disorders	☐ Yes ☐ No
Mononucleosis	☐ Yes ☐ No	Bridges/false teeth	☐ Yes ☐ No
Seizure	☐ Yes ☐ No		

5. Has your child been prescribed any medications that they are currently taking? ☐ Yes ☐ No

If yes, please list _____
_____
_____

Will your child be taking this/these medication(s) during the school day? ☐ Yes ☐ No

6. Does your child wear glasses, contact lenses, or use other vision correction products such as a visor for light or screens to correct astigmatism? ☐ Yes ☐ No

7. Please list any conditions, medical or otherwise, that might preclude your child from participating in sports.

_____
_____
_____
_____

Part B: Athletics Participation

to be completed by Parent/Guardian

I hereby give permission for my child to participate in the Faith Preparatory School's athletics and physical education programs, and any intramural, after-school, or extracurricular sports in which my child may be permitted to participate.

_____
(print name of student)

_____ Date: _____
(signature of parent/guardian)

_____
(print name of parent/guardian)

Part C: Emergency Contact Information

to be completed by Parent/Guardian

In emergency situations, how can you be reached? Please list at least two ways to contact you:

1. Work phone number: _____

Home phone number: _____

Cell phone number: _____

I am the: ☐ Mother ☐ Father ☐ Guardian ☐ Other (Describe relationship: _____)

2. Work phone number: _____

Home phone number: _____

Cell phone number: _____

I am the: ☐ Mother ☐ Father ☐ Guardian ☐ Other (Describe relationship: _____)

Part D: Emergency Treatment Release

to be completed by Parent/Guardian

I hereby give permission to Faith Preparatory School and any personnel deemed appropriate by Faith Preparatory School, which includes but is not limited to my child's host family, or any educational support personnel such as ESL instructors, to act on my behalf in emergency medical situations related to my child.

_____

(print name of student)

_____ Date: _____

(signature of parent/guardian)

_____

(print name of parent/guardian)

Part E: Parent/Guardian Consent Form for Over-the-Counter (Non-Prescription) Medications

to be completed by Parent/Guardian

I hereby give my child permission to receive the following over-the-counter (non-prescription) medications. I also give permission to competent medical counsel (including, but not limited to, attending physician and school nurse personnel) to provide such over-the-counter (non-prescription) medications as appropriate, if the school provides such medicines:

☐ Acetaminophen

☐ Ibuprofen

If you have not checked off all of the above, please explain omissions or refusals:

_____

_____

_____

One or more of my omissions or refusals is for allergy reasons. : ☐ Yes ☐ No

_____

(print name of student)

_____ Date: _____

(signature of parent/guardian)

_____

(print name of parent/guardian)

Part F: Prescription Medication Order & Parent/Guardian Consent Form

to be completed by the Prescribing Physician

● Part F is to be completed by the prescribing physician for any prescription medication, which includes, but is not limited to, epi-pens, respiratory inhalers, daily medications, or temporary antibiotic therapy.

● Schools may restrict a student's access to any prescription medications by requiring a school nurse or other competent, registered person to administer such medication or require that the medication be taken in the presence of such a person.

● Under controlling federal law, and Connecticut state law, a licensed nurse must have a Medication Order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication.

● The Parent/Guardian must give consent for the medication to be administered.

Student Name: _____

Grade: _____ Date of Birth: _____

Diagnosis:_____

Medication: _____

Route: _____ Frequency/Time: _____

Start Time: _____ Duration of Order: _____

Allergies: _____

Comments:_____

_____

_____

_____

_____
Signature of Licensed Provider

_____
Print Name of Licensed Provider

_____
Telephone

_____
Address of Licensed Provider

_____
Street City State/Province/District Country ZIP

I, the undersigned, give permission to school nurse personnel to administer the above-named medication(s) to my child. I understand that school personnel are not responsible for any problems arising from the taking of this medication, its side effects or for the omission of medication. I give permission to such nursing personnel to share information relevant to the prescribed medication administration as determined to be appropriate for my child's health and safety.

I understand that I may retrieve the medication from the school at any time, as may my child's host family. I understand that the medication will be destroyed if it is not picked up within one week following the termination of the order or one week beyond the close of school.

_____ Date: _____
(signature of parent/guardian)

_____
(print name of parent/guardian)

Part G: Certificate of Immunization and Physical Examination History

to be completed by the Attending Physician

Name: _____

(Please print full name as it appears on passport: Last, First, MI):

Date of Birth: _____ Sex: ☐ Male ☐ Female

All listed vaccinations MUST be administered prior to the student's arrival in the United States, including all up-to-date booster shots. It is the responsibility of prospective students, their families and agencies to ensure that immunization requirements are fully met before arrival to the United States. All immunization records must be in English and clearly legible, following the guidelines of State of Connecticut, Department of Education:

Before Age 5:	DTaP	At least 4 doses. The last dose must be given on or after 4th birthday
	Polio	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR	1 dose on or after 1st birthday
	Measles	Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
	Hib	Children less than 5 years of age need one dose at 12 months, or children 5 years or older do not need proof of Hib vaccination
	Hep B	3 doses
	Varicella	1 dose on or after the 1st birthday or verification of disease
Age 6-11:	DTaP/Td/Tdap	At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
	Polio	At least 3 doses. The last dose must be given on or after 4th birthday.
	MMR	1 dose on or after the 1st birthday
	Measles	Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
	Heb B	3 doses
	Varicella	1 dose on or after the 1st birthday and second dose at age 5 (entry to Kindergarten) or verificatio of disease.
Age 12+:	Td	3 doses, last dose on or after 4th birthday
	Tdap	1 dose
	Polio	3 doses, last dose on or after 4th birthday
	MMR	2 doses
	Heb	3 doses
	Varicella	2 doses or documentation of disease
	Meningococcal	1 dose

In accordance with CT State Law, all full-time international students must have a U.S. physician's medical examination. This will be conducted by a physician, a physician's assistant or an advanced practice registered nurse legally qualified to practice in the United States. The Host Family will schedule this upon arrival to Connecticut. A Health Assessment Form, http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/HAR.pdf, should be completed and submitted to the FPS School Nurse within 30 days of arrival.

If combination vaccine is administered, please indicate vaccine type

Hepatitis B	**Date and Vaccine Type**
	1
	2
	3
	4

Diptheria, Tetanus, Pertussis	**Date and Vaccine Type**
(Including all tetanus booster shots, Tdap)	**1**
	2
	3
	4
	5
	6
	7

Polio	**Date and Vaccine Type**
	1
	2
	3
	4
	5

Measles, Mumps, Rubella (MMR)	**Date and Vaccine Type**
	1
	2

Meningococcal conjugate	**Date and Vaccine Type**
	1
	2

Other	**Date and Vaccine Type**
	1
	2
	3
	4

Serologic Proof of Immunity		**Check one:**	
Test	**Date**	**Positive**	**Negative**
Measles			
Mumps			
Rubella			
Varicella (Chicken Pox)			
Hepatitis B			

Chickenpox History:

☐ Check the box if this person has a physician-certified reliable history of chickenpox.
Approximate date of chickenpox: _____

Reliable history is based on:

☐ Physician interpretation of parent/guardian description of chickenpox

☐ Physical diagnosis of chickenpox

☐ Serologic proof of immunity

Physical Examination:
Date of examination: _____
Height: _____ Weight: _____ Blood pressure: _____

Evaluations: Check = normal. If abnormal, please describe.

☐ General_____

☐ Skin _____

☐ HEENT _____

☐ Dental/Oral _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities _____

☐ Neurological _____

☐ Other _____

Screenings:

Vision			**Hearing**			**Postural**		
Right eye	□pass	□fail	Right ear	□pass	□fail	Scoliosis	□pass	□fail
Left eye	□pass	□fail	Left ear	□pass	□fail	Kyphosis	□pass	□fail
Stereopsis	□pass	□fail				Lordosis	□pass	□fail

Laboratory results:

☐ Lead Date_____ ☐ Pass ☐ Fail

☐ Other: _____ Date_____ ☐ Pass ☐ Fail

Targeted TB Testing must have been administered within 30 days of arrival in the United States.

Date of PPD: _____ Results: _____ mm.

☐ Medium to high risk

☐ Low risk

☐ Referred for evaluation to: _____

☐ The following treatment for TB has been administered:

_____

This student may participate fully in the school program, including physical education and competitive sports. ☐ Yes ☐ No

If no, please explain: _____

_____

_____

_____

_____

_____

_____

_____

Immunizations for this student are complete: ☐ Yes ☐ No

If no, please explain: _____
_____
_____
_____
_____
_____
_____

I certify that this immunization information was transferred from the above-named individual's medical records.

_____
Signature of Doctor or Nurse Date

_____
Print Name of Doctor or Nurse

_____
Facility Name

_____
Address of Facility

_____
Street City State/Province/District Country ZIP

Part H: Specific Cultural or Religious Needs that May Affect Treatment / Diagnosis of My Child

to be completed by Parent/Guardian

Circumstances, practices, or beliefs unique to my culture or religion, or the culture or religion of my child, exist that may have implications for the medical treatment, diagnosis, or postmortem care of my child.

☐ Yes ☐ No

If yes, please explain:

_____
_____
_____
_____
_____
_____

I understand that nothing described in Part I in any way exempts my child from any requirements imposed on my child by state or federal law, or by local school regulation, regarding vaccinations or otherwise. I understand that my description of these circumstances is purely for informational purposes to be exercised at the sole discretion of Faith Preparatory School and its various successors and assigns, including, but not limited to, host families and school medical personnel. I understand that my description of these circumstances in no way implies that my student's health insurance coverage will provide for culture-specific medical practices (such as acupuncture), just as I understand that such practices are not necessarily excluded by my student's health insurance plan. I understand that special nutritional requirements or other circumstances are to be discussed between my child and his or her international host family as appropriate.

_____

(print name of student)

_____ Date: _____

(signature of parent/guardian)

_____

(print name of parent/guardian)

Part I: Consent to Treatment, Consent to Release Medical Information, Waiver of Liabilities

to be completed by Parent/Guardian

I, the undersigned parent/guardian of my child, _____, do hereby grant permission to Faith Preparatory School and to any of its designated assigns, which includes, but is not limited to, my child's host family or designated caretaker individuals, the right to act on my behalf in taking actions appropriate for the treatment, diagnosis, and routine screening, which includes, but is not limited to, annual or semiannual physicals, routine dental exams such as cleanings, or special diagnostic screenings such as X-rays, if persistent symptoms indicate a need for such screening. I understand that it is ultimately my responsibility and my child's responsibility to cover any and all expenses relating to medical treatment or screening, emergency or non-emergency, which shall not be construed to exclude such costs as enrollment in a health insurance program or other expenses ancillary to but related to such diagnosis or treatment.

I additionally agree to release to Faith Preparatory School and the designated host family any of my child's medical records such as it may require, and further release to Faith Preparatory School the right to act, at its sole discretion, to release such medical records as may be required for the diagnosis and treatment of my child.

I additionally waive Faith Preparatory School, as well as its various successors and assigns, which includes, but is not limited to, host families, local school personnel, or certified medical personnel, of all liabilities relating to my child, including, but not limited to, medical treatment, transportation, or any other activities. Such waiver extends to any party deemed necessary by Faith Preparatory School, which may include,

without being limited to, host families or school personnel. I agree to indemnify and hold harmless Faith Preparatory School and its various successors and assigns, including but not limited to host families, Faith Preparatory School staff and employees, and contract employees such as ESL teachers, against any and all liabilities or damages that may arise out of my child's participation in the Faith Preparatory School international exchange program.

_____

(print name of student)

_____ Date: _____

(signature of parent/guardian)

_____

(print name of parent/guardian)

***This form is to be completed by Parent/Guardian and Physician as stipulated herein and returned to Faith Preparatory School prior to the child's participation in the Faith Preparatory School International Student Program.**