Character Before Career

The Stony Brook School

Dear Parent and/or Guardian:

Our mission at the Health Center is to serve the students, your children. When school is in session we have liberal clinic hours, and 24-hour-a-day emergency services. In the event of a serious medical situation involving your child, we will contact you expeditiously. For routine medical care, we ask your child to take the responsibility of informing you. Please review the following information:

Medication Policy

No Medications, including over the counter medications can be stored in the student' rooms, with the exceptions of inhalers for asthma or epi-pens for severe allergies and prescription medication that has been approved by Health Center Staff.

No medication may be mailed directly to students, it must be mailed to the Health Center.

The Authorization for the Administration of Medicines must be completed by both, parents and physician. Additional medication form can be found at The Stony Brook School's website.

If your child is taking medication, please contact the Health Center before arrival at school. We will assist you with making any necessary arrangements, so we are prepared to begin dispensing your child's medication.

Parents must keep a separate supply of medications at home, to be used for week-ends or vacations. We recognize that insurance companies will only pay for a one month supply, and you may have to purchase one month supply to keep at home.

It is the student's responsibility to take his/her daily medication to maintain their optimal level of health and performance. If a student is non compliant with the medication plan, it could affect performance and consequently his/her good standing in The Stony Brook community. Parents are welcome to call and speak to inquire about medication compliance.

Immunizations

The State of New York requires that no child shall be admitted to school without appropriate certification of immunization against diphtheria, poliomyelitis, measles, mumps, rubella and hepatitis B or has shown acceptable evidence of excuse for medical or religious reasons. The State of New York requires that "proof of immunization" be submitted each year. It is no longer acceptable to indicate that this information is "on file".

Billing /Insurance

All students are required to have health insurance prior to registration in August. If your child is covered by private, U.S. approved health insurance; you must provide **a copy of both sides of the insurance card.** If you need to enroll in the school -sponsored plan please fill out the application that was enclosed in your packet.

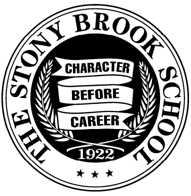
Families with HMO or PPO who need to select a primary physician for your child you must select from these towns because the health center is not able to provide transportation for students beyond these areas. (Stony Brook, Setauket, East Setauket, St. James, Port Jefferson, Port Jefferson Station, Nesconset, Smithtown, Lake Grove). The School's physician is Dr. Emrick Milligan, 487 Lake Ave., St. James, N.Y. 11780, telephone (631) 584-6014.

ALL international students are required to be enrolled in the School sponsored student medical plan and will have the participating insurance premium automatically charged to their tuition account. This is necessary because American healthcare providers will not bill foreign families or plans. This will assure our parents that there will be no interruption in medical care their child may require.

Physical examinations

All students are required to have a yearly physical examination. Please have your physician determine if your child is able to participate in sports at school. International students and student athletes returning to school early will not be allowed to participate unless all health forms have been received by Health Center. Please remember that our sole reason for being here is to care for and assist your child in your absence. Should you have any concerns or questions, we welcome your visit the Health Center or please give us a call any time (631-751-1800 x 523) or e-mail me at julie.gerbino@stonybrookschool.org. **ADDITIONAL HEALTH FORMS CAN BE LOCATED ON OUR WEBSITE:** www.stonybrookschool.org/Parents/Support/index.php.

Julie Gerbino, R.N., L..N.C.
Director of Health Services



The Stony Brook School

1 Chapman Parkway - Stony Brook, New York 11790-1799
TEL (631) 751-1800 • FAX (631) 751-9160

STUDENT HEALTH FORM (required every year)

Name ____ Date of Birth_ ____________ Student ID# ________ Sex: ___M ___F
Last First Middle month /day /year

Home Address____________________________________City:____________________State/Country:__________ Zip Code:____________

Parents / Guardian____ Home Phone:(______)________________________
Last First

Parents Cell Phone:(_____)____________________ Parent Fax # ____________________ Parents e-mail____________________________

Student resides with: Both parents _____ Father _____ Mother ______ Other_______ Student's Cell Phone:________________________

EMERGENCY CONTACTS

Primary Contact ___________________________ Home Phone : (_____)_________________ Cell Phone:(_____)___________________________

MEDICAL INFORMATION

Physician Name:______________________________________ Phone: (_____)______________________ Last Tetanus Shot_____/____/_____

ALLERGIES to food, drugs, insects____

Medical Conditions/Limitations:____

Current Medication:____

INSURANCE / POLICY HOLDER INFORMATION

All students are required to have insurance coverage. If you do not provide health insurance information on this form the student will automatically be enrolled in the School sponsored plan. The cost of this plan will be charged to your school account.

ALL international students are required to be enrolled in the School sponsored student medical plan and will have the participating insurance premium automatically charged to their tuition account. This is necessary because American healthcare providers will not bill foreign families or plans. This will assure our parents that there will be no interruption in medical care their child may require.

Name of Policyholder____ Soc. Sec.#____________________ Date of Birth__________

Name of Employer:____

Name/Address of Insurance Co.____

Policy#________________ Group#_________________ **Co-pay $_______** **Pharmacy Co-Pay $ __________** **Specialist Co-Pay $ ___________**

If your insurance company requires a change in primary physician please do so. Our school physician is Dr. Emrick Milligan (631) 584-6014. **Please attach photocopies of insurance cards- both front & back**. If you do not provide a copy of your card the service provider will not be able to bill your insurance company and the bill will be sent directly to you.

Permission For Treatment & To Release Summary Health Form in Emergencies

I herby give consent for the Stony Brook School Director of Health Services or other health care providers considered appropriate to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment, or counseling for my (son/daughter/ward). Should an emergency arise in which time is a factor and the school authorities are unable to contact me promptly, I authorize the school physician/nurse, Headmaster, or a school official, to exercise their judgment in the interest of my child's welfare. I also give permission for this Emergency Health Form to be released to those health service personnel or other appropriate health care providers who may need this information in order to treat my son/daughter/ ward in a medical emergency. I hereby authorize the physician/hospital to release any information to process an insurance claim. **I also authorize school personnel to give medications from the school formulary.**

Signature of Parent/Guardian:____date:______________

The Stony Brook School
1 Chapman Parkway
Stony Brook, New York 11790
TEL (631) 751-1800 • FAX (631) 751-4211

Athletic Consent Form

I am aware that playing or practicing to play/participate in any sport can be dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or practicing to play/participate in sports include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of the musculo/skeletal system, and serious injury or impairment to other aspects of the body, general health and well-being. I understand that the dangers and risks of playing or practicing to play/participate in sports may result not only in serious injury, but in a serious impairment of future abilities generally to enjoy life.

I also understand that there is a possibility of loss of or damage to contact lenses, glasses, dental/orthodontic appliances. I recognize that these can be lost or damaged during body contact activities and other vigorous exercise. I am willing to take the calculated risks involved and assume responsibility for replacement of the above should they be lost or broken.

In spite of the above risks, I still want my child to participate in sports because of the great values involved. I, therefore, give permission for my child to participate in all sports and activities sponsored by the School except for the ones I have listed below.

Signature of Parent/Guardian____ **Date**________________________

Print name of Parent/Guardian____

I, too, have read the above statement about the dangers involved in athletic activities. Because of these dangers, I recognize the importance of following coaches' instructions regarding playing techniques, training, and other team rules, etc., and I agree to obey such instructions.

Signature of Student ____ **Date**_________________________

Print name of Student ____

****IMPORTANT****
Parents: for those whose insurance companies will only cover one physical exam per year and that physical will need to take place after August 1, a Physician's note must be attached to the health form stating that "the student is in good health and physically able to participate in athletics and the immunizations are up to date."

PHYSICAL EXAMINATION

Students Name_______________________________ Date of Birth________________
(print)

Blood Pressure ________/_________ Pulse ____________ Height _____ft. ______in. Weight ____lbs. BMI ______
Vision: Right 20/_______ Corrected 20/________ Urinalysis date _____________
Left 20/_______ Corrected 20/________ Sugar _____ Albumin________

	√= Normal	√= Abnormal comment
1. Head, Ears, Nose, or Throat		
2. Eyes (with Ophthalmoscope)		
3. Hearing		
4. Neck-Thyroid		
5. Respiratory		
6. Cardiovascular		
7. Gastrointestinal		
8. Hernia		
9. Genitourinary		
10. Metabolic/ Endocrine		
11. Neuropsychiatric		
12. Skin		
13. Menstrual		

	Yes	No
14. To the best of your knowledge is this person free from physical or mental impairment including alcohol or drug dependency?		
15. Are there any restrictions of physical activity (athletics, gym, etc.)		
16. Is this patient now under treatment for any medical or emotional condition?(comment below)		
17. Is the patient on long-term medication? (if yes specify)		

IMMUNIZATIONS:
The State of New York requires that no child shall be admitted to school without appropriate certification of immunization against diphtheria, poliomyelitis, measles, mumps, rubella and hepatitis B or has shown acceptable evidence of excuse for medical or religious reasons. Specifically, this means that the child has received:
- 3 or more doses of diphtheria toxoids (usually administered as either DTP or TD).
- Either 3 or more doses trivalent oral poliovirus vaccine (TOPV) or enhanced inactivated poliovirus (EIPV), or 4 doses inactivated poliovirus (IPV).
- 2 doses live measles vaccine administered on or after first birthday, or history of physician-diagnosed measles disease, or evidence of immunity.
- Either 1 dose of live mumps vaccine administered on or after first birthday, or a history of physician-diagnosed mumps disease, or serologic evidence of immunity.
- Either 1 dose of live rubella vaccine administered on or after first birthday, or serologic evidence of immunity.
- 2 doses of MMR may be given in place of measles, mumps and rubella.
- 3 doses of Hepatitis B for 7th and 8th graders.
- **Varicella immunization**

Immunization Record- Fill in all vaccines received –month and year

DPT			
HIB			
OPV			
IPV			
Td			
MMR			
Measles			
Mumps			
Rubella			
Hepatitis B			
Meningcoccal			
Varicella			

PPD Mantoux Test (*required within one year prior to first year at School*)
Date______ Results__________mm
If test is positive, chest x-ray is required, attach report, results and treatment

Signed______________________________
(Examining Practitioner)

Date of examination ________________________

Name____________________________________
Address__________________________________
Telephone # (___)______________________ fax #______________________

WHEN COMPLETED, MAIL DIRECTLY TO: THE STONY BROOK SCHOOL, 1 CHAPMAN PARKWAY, STONY BROOK, N.Y. 11790

FAMILY AND PERSONAL MEDICAL HISTORY

FAMILY HEALTH HISTORY	YES	NO
Tuberculosis		
Diabetes		
Kidney Disease		
High Blood Pressure		
Arthritis		
Stomach Disease / Ulcer		
Asthma, Hay Fever, Eczema		
Epilepsy, Convulsions		
Cancer		
Emotional Problems		
Anemia		
Alcohol / Drug Abuse		

PERSONAL HEALTH HISTORY	YES	NO		YES	NO
Scarlet Fever Disease			Rheumatic Fever		
Measles Disease			Heart Murmur		
Mumps Disease			High Blood Pressure		
Chicken Pox Disease			Dizziness or Fainting		
Mononucleosis Disease			Convulsions or Epilepsy		
Malaria Disease			Arthritis		
Sinusitis			Back Problems		
Diabetes			Stomach or Intestinal Trouble		
Frequent Anxiety			Jaundice or Hepatitis		
Frequent Depression			Recurrent Diarrhea		
Worry or Nervousness			Surgery(list dates)		
Recurrent Headaches			Head Injury		
Recurrent Colds			Trauma/ Injury		
Allergies (spec.) Penicillin			Transfusions		
Allergies: other drugs			Urinary Tract Infections		
Hay Fever, Asthma			History of Fractures		

Medication	YES	NO
Are you currently taking any medication?		
Please list : (include birth control pills)		

New York State Department of Health requires Authorization for the Administration of Medications.

Parent/ Guardian and Physician signature required.

Tylenol 325mg 1-2 tabs every 3-4hours
Ibuprofen 200-800mg every 4-6 hours
Pseudophrine (Sudafed) 30mg. 1-2 tabs every 4-6 hours
Benadryl 25mg 1-2 tabs every 4-6 hours
Milk of Magnesia 30 cc, hours of sleep, as needed
Mylanta 30cc
Tums chewable tabs
Anbesol for cold sores
For severe allergic reactions: EPI-PENN (epinephrine 1-1000) 0.3cc IM
Emetrol 1-2 tsps as needed
Immodium AD 1 capsule every 4-6 hours as needed
Claritin 1 tab q24hrs prn
Tussin 2 tsp every 4 hours prn
Zyrtec 1 tablet q24hrs prn

Parent or guardian______________________________ Date______________

Physician signature______________________________ Date______________

Address ______________________________ Phone #______________

THE STONY BROOK SCHOOL 2012-2013 SCHOOL YEAR

Student's Name ____ Current Grade____________ Date of Birth _______________

Dear Parent:

In order for medication to be taken in school by day students, New York State Law requires a written request from your family physician including frequency and the dosage. Also, the nurse must have on file a written request from the parent to administer the medication. A new form must be filled out for each change of dosage. This procedure must be repeated yearly for **both** day and boarding students.

*** To be completed by the Physician ***

Specific Diagnosis ______________________________________ Name of Medication __________________________________

Dosage Amount ____ Time/Frequency _____________________________________

Route of Administration _________________________________ Duration of Regimen_________________________________

For prn (as necessary) medication: conditions under which medication should be given ____________________________

Side effects to expect ______________________________________to report ____

Unless indicated otherwise, the following conditions for medication administration are in effect:

- The physician and parent or guardian certify that the student has been instructed in the proper use of the above medication procedure and may self-administer the medication, unless the medication is a controlled substance, narcotic or anti-depressant.
- The physician and parent/guardian request that the student be permitted to carry the medication on his/her person or to keep the same in his/her locker as he/she is considered responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.
- Please note that certain medications such as **Adderall, Ritalin, antidepressants and narcotics must be kept at the Health Center.** Any medications that are in this category must be delivered directly to the school nurse in an original container, labeled by the pharmacist, and including the name of the medication. Please contact the Health Center with any questions.

____ Date_____________
Signature of Physician/title

Physician's name (printed)____ **Phone Number** ___________________

____ Date _____________
Signature of Parent/Guardian and relationship to the student