



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.

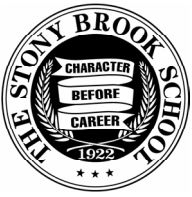
Families with HMO or PPO who need to select a primary physician for your child you must select from these towns because the health center is not able to provide transportation for students beyond these areas. (Stony Brook, Setauket, East Setauket, St. James, Port Jefferson, Port Jefferson Station, Nesconset, 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@stonybrookschoo.org. **ADDITIONAL HEALTH FORMS CAN BE LOCATED ON OUR WEBSITE:** www.stonybrookschoo.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: _____ ZipCode: _____

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 hereby 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 pro-viders 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 _____

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			
Meningococcal			
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 2011-2012 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.

Signature of Physician/title _____ Date _____

Physician's name (printed) _____ Phone Number _____

Signature of Parent/Guardian and relationship to the student _____ Date _____