New York Military Academy

CONTACTS AND PERMISSION TO TREAT

(Must be Signed by a Parent/Guardian • Infirmary fax 845-534-5132)

Student's Full Name: _____ _____ _____
Last First Middle Initial

Address: _____ _____ _____ _____ _____
Street City / Town State Zip Country

Sex: ☐ M ☐ F Date of birth: _____/_____/_____
Month Day Year

All of the information on this form is confidential and will be used only for the purpose of evaluating your child's health status and facilitating medical diagnosis, care, and/or treatment and the processing of insurance claims in connection therewith.

CONTACTS

Mother's Name _____ Father's Name _____

Home Phone _____ Home Phone _____

Cell _____ Cell _____

Work Phone _____ Work Phone _____

Email _____ Email _____

ALTERNATE EMERGENCY CONTACT OTHER THAN PARENTS

Name _____ Relation _____

Home Phone _____ Cell _____ Work Phone _____

PRIMARY CARE PHYSICIAN

Physician's Name _____ Phone _____

Date of Last Physical _____ Last Date of Tetanus _____

MEDICAL INFORMATION

Allergies: _____

Medications: _____

PSYCHOLOGICAL INFORMATION

Has student ever received or is presently receiving counseling? NO _____ YES _____ If yes, dates: _____

If yes, please provide a letter stating condition and progress in detail and medications.

INSURANCE INFORMATION

A photocopy (front and back) of students insurance card. Insurance plan must be able to cover student in the state of New York.

PERMISSION TO TREAT

I hereby give consent for the Medical Staff of New York Military Academy to carry out accepted procedures for diagnos immunizations, medical and minor surgical treatment, to give my child daily medications or medications as needed in the health office, and have access to all medical records.

I authorize the Medical Staff & School Officials of New York Military Academy to take any action believed necessary for the best interest of my child including routine medical and emergency room treatment by any hospital staff, surgeon, physician, radiologist or dentist, and any counseling or psychological evaluation.

Signature of Parent or Guardian _____ Date _____

New York Military Academy

Immunization/Health History and Physical Exam Form

(Must be Signed by a Parent/Guardian and a Physician • Can be Substituted with an Equivalent Form • Infirmary fax 845-534-5132)

Student's Full Name: _____ (Last) _____ (First) _____ (Middle Initial)

Sex: ☐ M ☐ F Date of birth: ____/____/____ (Month / Day / Year) Home Phone Number: _____

Address: _____ (Street) _____ (City / Town) _____ (State) _____ (Zip) _____ (Country)

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today
❒ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❒ Positive ❒ Negative ❒ Not done Date: _____
PPD: ❒ Positive ❒ Negative ❒ Not done Date: _____
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: _____
Dental Referral ❒ Yes ❒ No ❒ Not done Date: _____

Significant Medical/Surgical History: _____

Allergies: ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Other: _____
❒ Seasonal ❒ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	☐ Y ☐ No
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	☐ Y ☐ No
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	☐ Y ☐ No
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	☐ Y ☐ No

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): _____

Each medication that is prescribed or taken regularly **must** be accompanied by a Prescription Medication Authorization Form

PHYSICAL EDUCATION / SPORTS

❒ **Free from contagions & physically qualified for all physical education, sports, military & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: _____ ❒ None

❒ **Known or suspected disability:** _____ ❒ Please monitor

❒ **Restrictions:** _____ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent/Guardian Signature: _____ **Date:** _____

New York Military Academy

OVER-THE-COUNTER (OTC) MEDICATION AUTHORIZATION FORM

(Must be Completed and Signed by a Parent/Guardian and a Physician • Infirmary fax 845-534-5132)

Student's Full Name: _____ _____ _____
Last First Middle Initial

Sex: ☐ M ☐ F Date of birth: ____/____/____ Weight:_____
Month Day Year

List Allergies:_____

Describe reaction: _____

Over-the-counter (OTC) medications are drugs that do not require a prescription to purchase. In New York State a licensed prescriber's (Physician, Dentist, Nurse Practitioner, Physician Assistant, etc.) order is required for any medications including OTC and prescribed drugs to be administered at school by the school nurse.

This form must be completed in full and submitted before any OTC medications may be administered to a student. New York Military Academy (NYMA) maintains a limited stock of OTC medications available in the infirmary for ***occasional or short-term*** use. Any OTC drugs requiring ***frequent or daily*** administration should be provided by the parent, in the original labeled container, and must be accompanied by this form. This form is valid only for the current school year or summer.

Please check "yes" or "no" to authorize designated NYMA staff to administer the following medications to this student while on campus. OTC medications are administered per manufacturer's directions according to age and/or weight unless a licensed prescriber provides other written directives. The following OTC medications are stocked by NYMA and are generic versions of the brand names listed. If a specific brand is required it must be provided to the infirmary by the student's parent(s).

OTC medication administered per manufacturer's directions	**Indications**	**Yes**	**No**	**Comments**
Acetaminophen (Tylenol)	Pain reliever/ fever reducer	☐	☐	
Ibuprofen (Advil, Motrin)	Pain reliever/ fever reducer	☐	☐	
Acetaminophen/Pamabrom (Midol Teen)	Menstrual cramps	☐	☐	
Acetaminophen/Aspirin/Caffeine (Excedrin Extra Strength)	Pain reliever/fever reducer	☐	☐	
Acetaminophen/Dextromethorphan/Guaifenesin/Phenylephrine (Sudafed PE)	Pain reliever/fever reducer, cough and congestion	☐	☐	
Guaifenesin (Mucinex, Robitussin)	Nasal and sinus congestion	☐	☐	
Dextromethorphan/Guaifenesin (Mucinex DM)	Nasal and sinus congestion, Cough	☐	☐	
Cough drops or throat lozenges	Cough/Throat irritation	☐	☐	
Phenol (Chloraseptic spray)	Throat irritation	☐	☐	
Benzocaine (Orajel, Sting relief swabs)	Toothache, Insect stings	☐	☐	
Diphenhydramine (Benadryl and Benadryl Spray)	Allergic reactions (hives, rashes, insect bites, upper respiratory reactions)	☐	☐	
Cetirizine Hydrochloride (Zyrtec)	Seasonal allergies	☐	☐	
Loratadine (Claritin)	Seasonal allergies	☐	☐	
Ketotifen eye drops (Zaditor)	Eye itching and irritation	☐	☐	

New York Military Academy

OVER-THE-COUNTER (OTC) MEDICATION AUTHORIZATION FORM

(Must be Completed and Signed by a Parent/Guardian and a Physician • Infirmary fax 845-534-5132)

OTC medication administered per manufacturer's directions	Indications	Yes	No	Comments
Tetrahydrozoline eye drops (Visine)	Eye irritation and redness	☐	☐	
Calcium Carbonate (Tums)	Heartburn, acid reflux	☐	☐	
Bismuth Subsalicylate (Pepto-bismol)	Diarrhea, Heartburn, Upset stomach	☐	☐	
Loperamide Hydrochloride (Imodium)	Diarrhea	☐	☐	
Simethicone (Gas-X)	Abdominal pressure, fullness, bloating	☐	☐	
Senna (Senokot, Ex-lax)	Constipation	☐	☐	
Calamine lotion	Skin irritation and itching	☐	☐	
Benzalkonium/Lidocaine spray (Bactine)	First aid antiseptic, Pain relief for minor cuts, scrapes, and burns	☐	☐	
Bacitracin/Neomycin/Polymycin B ointment (Neosporin, Triple antibiotic)	Prevent infection of minor cuts, scrapes, and burns	☐	☐	
Menthol USP topical gel (Biofreeze, Icy Hot)	Cooling relief for muscle pain	☐	☐	
Sunscreen	Prevent sunburn	☐	☐	
Deet-free Insect Repellant	Prevent insect bites	☐	☐	

Please add any other OTC medications that will be provided by the parent(s) for this student. Do not include prescription medications in this location.

OTC medication administered per manufacturer's directions	Indications:	Comments

I give permission for the medication(s) listed above to be administered to this student on an as needed basis to be determined by the school nurse's assessment. Should this student develop any condition or begin taking medication that would affect the ability to take any of the above medications safely or need to terminate the use of this medication for any reason a parent or guardian will notify the school nurse immediately.

Parent/Guardian's Name (Please Print): _____

Parent/Guardian's Signature: _____

Physician's Name: _____

Physician's Signature: _____

New York Military Academy

PRESCRIPTION MEDICATION AUTHORIZATION FORM

(Must be Completed and Signed by a Parent/Guardian and a Physician • Infirmary fax 845-534-5132)

Student's Full Name: _____ _____ _____
Last First Middle Initial

Sex: ☐ M ☐ F Date of birth: ____/____/____ Allergies: _____ Epi-Pen: ☐ Yes ☐ No
Month Day Year

In New York State a licensed prescriber's (Physician, Dentist, Nurse Practitioner, Physician Assistant, etc.) order is required for any medications to be administered at school by the school nurse. This form must be completed in full by the licensed prescriber for any medications that will be given at school. **A separate form must be completed for each prescribed medication**. Any change in the medication administration requires submission of an updated form (ex. Change in dosage or time of administration). This form should be used for any Over the Counter (OTC) medications that are used frequently or daily (ex. daily allergy medications such as claritin or zyrtec).

All medication must be submitted to the school nurse in the original container provided and labeled by the pharmacy that filled the prescription. "Sample" and OTC medications should be in their original container that appropriately identifies the contents.

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day:	Is this medication PRN? Yes ☐ No ☐
Anticipated number of days medication will be given at school: until end of current school year _____ weeks _____ days	If yes, specify when indicated (signs/symptoms): Frequency: Is this Medication a controlled substance? Yes No
Possible side effects:	

Self-carry/Self-administration of emergency medication such as inhalers and EpiPens must be authorized by the prescriber and approved by the school nurse according to the State Medication Policy:

Prescriber's authorization for self-carry/self-administration _____ _____
Signature Date

School Nurse (RN) approval for self-carry/self-administration _____ _____
Signature Date

_____ _____
Prescribing Health Care Provider's Signature Date

Stamp, Print or Type Health Care Provider's Name & Address	Office Phone Number
	Office Fax Number

Section to be completed by child's parent or guardian

I give permission for my child _____, to be given the above named medication as prescribed. I give permission for New York Military Academy's Medical staff and school officials to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to New York Military Academy's Medical staff and school officials. I understand that the school requires I agree to the school rules about medications before this medication will be given at school. I understand that I am responsible to notify the school if my child's medications change in any way.

Parent/Guardian Signature: _____ Date: _____

NYMA Media Consent and Release

Cadet Last Name_____ First Name_____ Middle Initial_____

Preferred Name: _____ Date of Birth_____

As a parent or guardian of this student, I grant New York Military Academy and its agents and employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of this student, myself, or other members of my family for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium. I hereby release New York Military Academy and its legal representatives from all claims and liability relating to said images. Furthermore, I grant permission to use my statements that were given during an interview or guest lecture with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

Parent/Guardian Signature	*Date*	*Relation to the Cadet*