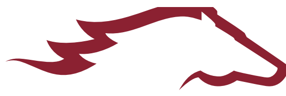


FOXCROFT
ACADEMY

HEALTH & MEDICAL RECORD QUESTIONNAIRE

** These forms must be complete before students can enroll at classes in Foxcroft Academy.*

Student Information

Student's Name: ____________________________ DOB (mm/dd/yyyy)__ / __ / ____
Address:____
City: _____________________ Country: ________________________________
Telephone: ________________ Email: __________________________________

Physician Information

Physician's Name: ____
Address:____
City: ________________________ Country: ______________________________
Telephone: ___________________ Fax: _________________________________

Medical History

Have you had? Please check all that apply.

Measles	Concussion or Head Injuries	Sexually Transmitted Disease
Mumps	Rheumatic Fever or Heart Disease	Strokes
Chickenpox	Diabetes	Tuberculosis
Epilepsy	Cancer	Broken Bones
Hepatitis	BCG inoculation ____________ (Date)	

Have you ever been hospitalized, had surgery, or been under extended Medical care?
No Yes If yes, for what reason? ____

Systemic Overview & History

Do you have the following? Please check all that apply.

Double vision	Eyeglasses	Eye disease or injury
Headaches	Glaucoma	Chronic sinus trouble
Nosebleeds	Ear disease	Impaired hearing
Hearing aids	Dizziness	Episodes of unconsciousness

Skin:

Abnormal pigmentation	Jaundice	Frequent infection or boils
Skin disease, hives, eczema		

Neck:

Stiffness	Thyroid trouble	Enlarged glands

Respiratory:

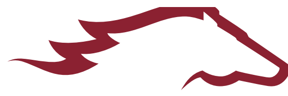
Spitting up blood	Asthma*[1]	Chronic or frequent cough

Endocrine:

Diabetes*[2]	Thyroid Problems	Other: ______________________

Have you been in good general health most of your life?
No Yes If not, please explain____
____
____

***1 – Students with asthma who use inhalers must have a written asthma plan included with file. They may carry inhalers with them at Foxcroft Academy.**
***2 – Students with diabetes must have written orders from a physician about their specific treatment plan prior to arrival.**



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Allergies and Sensitivities

Does the student have any allergic reactions to the following:

1. Medications / Herbs? No Yes *If yes, please explain.* ______

*What kind of reaction occurs? ______

2. Food? No Yes *If yes, please explain* ______

*What kind of reaction occurs? ______

3. Pets or Animals? No Yes *If yes, please explain* ______

*What kind of reaction occurs? ______

4. Any other allergies? (i.e. – latex, dust, environmental) No Yes *If yes, please explain*

*What kind of reaction occurs? ______

5. If you answered ***YES*** to any of the items above and the student has exposure to the allergen what type of treatment is used? ______

a. Epinephrine Pen No Yes

* If student requires the use of an epinephrine pen, he/she needs to bring one with him/her and be able to demonstrate proper use to school nurse.

b. Antihistamines such as: Benadryl, Zyrtec, Claritin No Yes

c. Other remedies? No Yes If yes, please explain: ______

Mental Health

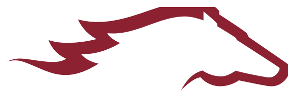
Have you ever received any medical attention or counseling for psychological or emotional issues? No Yes *If yes, please explain.* ______

Have you ever received pharmacological treatment (medication) for a psychological or emotional issue? No Yes *If yes, please explain.* ______

We certify that the information supplied is true and complete to the best of our knowledge. We authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of medical records for purposes of processing this application. Undisclosed information or inaccuracies in information provided could result in dismissal from Foxcroft Academy.

Signature of Student: ______ Date: ______

Signature of Parent: ______ Date: ______



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MEDICAL EXAMINATION FORM

to be completed by Family Physician

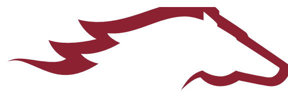
Physician Information

Physician's Name: ____
Address: ____
City: __________________________ Country: ____________________________
Telephone: ______________________ Fax: ________________________________

Examination Results

Normal	Check each item	Abnormal
. ……..	Head, Face, Neck, Scalp	
. ……..	Nose	
. ……..	Sinuses	
. ……..	Mouth and Throat	
. ……..	Ears- General (interior & exterior)	
. ……..	Ear Drums (perforated)	
. ……..	Eyes	
. ……..	Ophthalmoscopic	
. ……..	Pupils	
. ……..	Ocular Motility	
. ……..	Lungs and Chest	
. ……..	Heart	
. ……..	Vascular System	
. ……..	Abdomen and Viscera	
. ……..	Anus and Rectum	
. ……..	Endocrine System	
. ……..	G – U System	
. ……..	Upper Extremities	
. ……..	Feet	
. ……..	Lower Extremities	
. ……..	Spine, other Musculoskeletal	
. ……..	Body Marks, Scars, Tattoos	
. ……..	Skin Lymphatics	
. ……..	Neurologic	
. ……..	Psychiatric	
. ……..	Pelvic (female only)	

Examination: vaginally rectally



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Physical and Laboratory Results

Height: ____________ cm / in Weight: ______________ kg / lb

Color Eyes: ___________ Build: slender medium heavy

Hair Color:____________

BLOOD PRESSURE
Sitting: _______/_________ Recumbent: _______ / ______ Standing: ______ / _______

PULSE
Sitting: _______ After Exercise: ______ 2 minutes After : ________

LABORATORY FINDINGS
Urinalysis (Albumin/Sugar/A.Specific Gravity): ______________________
Serology (For any students with potential exposure to HIV or any form of Hepatitis, an antibody/antigen test is required with results sent to us. Specific to Hepatitis, an LFT test is required with results sent to us): _______________
Blood type & RH Factor: ___________________________

*****Required for students from endemic countries*****
Tuberculosis (Clearance must be within 6 months)
Chest X-Ray Date: _________ Positive or Negative: __________
Skin Test Date: ____________ Positive or Negative: __________

Medications

Are you currently taking medication for any reason? No Yes

If yes, please list.

____

____

Physician Signature

Signature of Physician: _______________________________

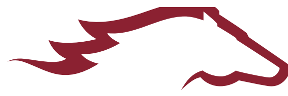
Printed Name: _______________________________

Date of Exam: ____________________

We certify that the information supplied is true and complete to the best of our knowledge. We authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of medical records for purposes of processing this application.

Signature of Student: _____________________________ **Date:** ____________

Signature of Parent: ______________________________ **Date:** ____________



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IMMUNIZATION RECORD FOR SCHOOL ADMITTANCE

to be completed by Family Physician

Immunization Requirements

Pupils enrolled in kindergarten through grade 12 (in the United States) are required to have written proof on file at their public or nonpublic school that they have been immunized against DPT (diphtheria, pertussis, tetanus), poliomyelitis, measles, mumps and rubella and Hepatitis B. Failure to do so is cause for exclusion from school. Required immunizations may vary from state to state.

MINIMUM IMMUNIZATION REQUIREMENTS:

* Five or more doses of DPT, DT (Pediatric), TD (Adult) vaccine or a combination thereof;
* Three or more doses of trivalent oral polio vaccine (TOPV), or (IPV);
* Two doses measles vaccine;
* Two doses mumps vaccine;
* Two doses rubella vaccine;
* One dose of Varicella;
* Three doses of Hepatitis B;
* MCV4 (Meningococcal)

If the final dose of any of the above vaccines occurs before the thirteenth (13th) birthday, a booster shot is required.

Immunization Record

DPT	1. Date	2. Date	3. Date	4. Date	5. Date	*Booster if required* Date
TOPV	*Date of Disease*	1. Date	2. Date	3. Date	*Booster if required* Date	
Measles	*Date of Disease*	1. Date	2. Date	*Booster if required* Date		
Mumps	*Date of Disease*	1. Date	2. Date	*Booster if required* Date		
Rubella	*Date of Disease*	1. Date	2. Date	*Booster if required* Date		
Hepatitis B	*Date of Disease*	1. Date	2. Date	3. Date		
Varicella (chickenpox)	*Date of Disease*	1. Date	2. Date	3. Date		
MCV4 (Meningococcal)	*Date of Disease*	1. Date	2. Date			

Physician Signature

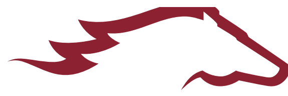
Physician Signature: ______________________________

Physician Printed Name: ______________________________

Date: ________________

Phone: ______________________ Fax: ______________________

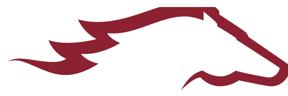
***Any immunization not available in your country are available here, but are expensive and may not be covered by insurances. Any necessary payment will be the responsibility of the student/family. Please make every effort to obtain all immunizations before your departure from your home country.**



Guidelines for Medication Administration

The following is a list of guidelines that must be followed for any medication to be administered at Foxcroft Academy.

1. The school nurse must have written notification from student's healthcare provider, on the school form or prescription pad of the following:
   a. Name of the medication.
   b. Condition being treated.
   c. Dosage and times the medication is to be given.
   d. If the medication is other than an oral medication, the route should also be stated.
2. All medications must be in their original container with the label. Whenever possible, labels should be in English. If they are in another language, then an English translation of the label must be given to the nurse. All containers must also be labeled to match the prescription written by the healthcare provider.
3. All medication will be supplied to the nurse, either in person or through the mail in a timely fashion. Deviation from this policy may cause a delay or interruption in receiving the medication. The nurse does not provide reminders.
4. It is not considered ethical for healthcare providers to write prescriptions for their own children. Please seek the services of another healthcare provider.
5. Herbal and homeopathic medication in any form will be treated as medications, not as supplements. Please note that if any of these are found to be controlled or illegal substances in the U.S., then an acceptable alternative medication must be used instead.
6. Unclaimed medications shall be disposed of after 2 weeks. Controlled substances cannot be sent via mail.
7. ***All medications must be administered by or under the direction of the nurse or dorm staff on duty.*** This includes all over-the-counter medications, prescriptions, and anything that appears to be or takes the form of medicine. Students may administer their own vitamins but should give the nurse a list of what they are taking.
8. Refills are the sole responsibility of the parents/guardian. The nurse will not be responsible for medication refills even if a local physician is used.



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MEDICATIONS BEING TAKEN

Routine Medications

Please list all routine medications. This includes medications taken for a temporary illness and even over-the-counter medicines, which, according to a physician's orders, must be taken at a higher dosage than recommended on the packaging. Medications must be accompanied by a written statement from the prescribing physician detailing the administration of the medicine. Medications are distributed at breakfast (B), Lunch (L), dinner (D), and bedtime (BT). The student should bring at least a one-month's supply when he/she first arrives at the school.

____ This student takes NO medications on a routine basis.
____ This student takes medications as follows:

Administered (Circle all that apply.)

Med #1: ______________________________ Dosage:__________ B L D BT
Reasons for taking: ____

Med #2: ______________________________ Dosage:__________ B L D BT
Reasons for taking: ____

Med #3: ______________________________ Dosage:__________ B L D BT
Reasons for taking: ____

Med #4: ______________________________ Dosage:__________ B L D BT
Reasons for taking: ____

Additional Medication Information:

____
____
____

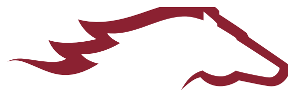
*If additional space is needed for medications please use reverse side of this document and your signature is REQUIRED.

Dental / Vision

Date of last dental check-up: ______________________________
Does student wear braces? No Yes
Date of last eye exam: ________________________________
Does student require corrective lenses? No Yes
* Students are advised to bring a second pair of eyeglasses or contact lenses with them at the beginning of the school year.

SPECIAL NOTES: Parent/guardians are responsible for sending medication refills directly to the nurse. The nurse is not responsible for providing reminders when refills are needed. If you will be using a local pharmacy, please arrange for direct payment with them.

____ _____________
Parent/Guardian's signature Date



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Medication List

When students are sick at Foxcroft Academy, it is often considered wise to provide them with over-the-counter medication for symptom relief, thereby increasing their comfort level. The dorm staff on duty, with the assistance of the nurse, may decide which medications are useful in illnesses not requiring a healthcare provider's evaluation.

If there are any medications which the student should not have, please list them here as well as the reason for this decision.

____

____

____

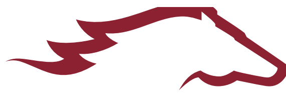
____

____

*PLEASE NOTE
Medications needed for temporary illness, on a short-term basis, will be provided to that student at no extra expense. If the student required long-term use of an over-the-counter medication, the nurse or dorm staff will provide him/her with a supply at the parent's expense, which will be dispensed only to this student.

As clearly stated in Foxcroft Academy's guidelines for medications, all of the above mentioned medications may not be kept in a student's room. Providing a student with these medications to keep in his/her room can result in disciplinary action for the student.

____ __________________
Parent/Guardian's signature Date



Asthma Medications

Some asthma medications are taken every day. These are long-term control medications. Medications may be distributed at breakfast (B), lunch (L), dinner (D) and bedtime (BT). Please list medications/dosage taken every day.

_____ This student takes NO long-term control medications for asthma.
_____ This student takes medications as follows:

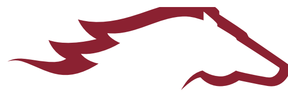
		Administered (Circle all that apply.)			
Med #1: ______________________	Dosage:____________	B	L	D	BT
Med #2: ______________________	Dosage:____________	B	L	D	BT
Med #3: ______________________	Dosage:____________	B	L	D	BT

Some medications are taken only when a student is having an asthmatic episode. These are quick relief medications. Please list medications/dosage that may apply:
____ This student takes NO long-term control medications for asthma.
____ This student takes medications as follows:

		Administered (Circle all that apply.)			
Med #1: ______________________	Dosage:____________	B	L	D	BT
Med #2: ______________________	Dosage:____________	B	L	D	BT
Med #3: ______________________	Dosage:____________	B	L	D	BT

Do you have a peak flow meter? _____ YES _____ NO
If yes, please bring the peak flow meter with you to school.
If yes, please comment below on what your peak flow zones have been:
____

Please list possible/known allergies that are aware of that have been asthma triggers:
____



F O X C R O F T

A C A D E M Y

Travel Medication Policy

Foxcroft Academy cannot assume responsibility for the medication needs of a child when traveling outside of the supervision of the school. The school will provide medications to students leaving campus for weekends or breaks, provided that the parent/guardian has provided the school with signed authorization, and the prescribed medications are available.

I/We give ____________________________________permission to transport his/her medications from school to the location where he/she is traveling to spend the weekend and/or break. I assume all responsibility for the medication from the time it is given to my child, until it is returned to the nurse or dorm staff at Foxcroft Academy.

____ ______________________

Parent/Guardian's signature Date

____

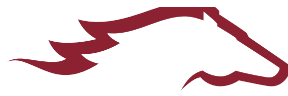
Printed Name

____ _________________________

Student's signature Date

____

Printed Name



FOXCROFT
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AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT AND FOR RELEASE OF INFORMATION

**** THIS FORM MUST BE COMPLETED TO ENTER SCHOOL AS A BOARDING STUDENT.***

Every effort is made to contact and inform a student's parents or guardian in case of medical emergency, mental health emergency, serious injury, or surgical illness requiring immediate surgical intervention. Residential students are cared for primarily by Mayo Practice Associates, Mayo Regional Hospital and Eastern Maine Medical Center (EMMC), respectively the medical practice and Emergency Department located in Dover Foxcroft and Bangor, Maine. In addition, students may be referred for care to other providers, specialists and hospitals in our locale.

On isolated occasions the parents or guardian cannot be reached. Accordingly, they are requested to sign the following statement:

In the event of illness or accident involving our/my son/daughter, __________________, we/I hereby give permission to Foxcroft Academy, its officials, and all physicians, surgeons, therapists and dentists retained by the school, to secure and furnish medical, mental health, dental or surgical care and treatment for him/her; and to give, administer and render any treatment or aid deemed necessary to protect, preserve, and safeguard the life and/or health of our/my son/daughter. This includes any immunizations, diagnostic x-rays or scans, blood testing, anesthetics, or surgery.

We/I further authorize Mayo Practice Associates, Mayo Regional Hospital and EMMC to exchange all health care information regarding the medical, mental health, dental or surgical care of my/our son/daughter to and from Foxcroft Academy's Head of School, Assistant Head of School for Boarding, Director of Residential Life and to and from their school nurse or designee. This information will be used to allow Foxcroft Academy to provide continuity of care to my/our son/daughter. It will also allow Foxcroft Academy to keep me/us aware of all current health information.

We/I further authorize Foxcroft Academy to release information regarding the medical, surgical, dental or mental health care of my/our son/daughter, ___________________, as is necessary for the completion of a claim for health insurance.

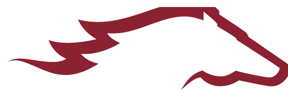
This authorization shall remain in effect for the duration of enrollment at Foxcroft Academy, terminating upon graduation.

Please answer the following questions about the person named above for influenza vaccine each fall:

1. Does this person have a severe (life-threatening) allergy to eggs? __Yes __No
2. Has this person ever had a severe reaction to an influenza vaccine? __Yes __No
3. Has this person ever had Guillain-Barre Syndrome? __Yes __No

_________________________________ _____________________ ___________

Signature of Parent or Guardian *Printed Name* *Date*



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HEALTH INSURANCE INFORMATION FORM

*Please attach copies of Insurance Policies or Insurance Cards

Student Information

Student's Name: ______________________________

Address: ______________________________

City: ____________ Country: ______________

Telephone: ______________

Physician Information

Physician's Name: ______________________________

Address: ______________________________

City: ____________ Country: ______________

Telephone: ____________ Fax: ______________

Practicing Health Facility Name: ______________________

Insurance Information

Insurance Company:

____

Address:

____

City: ____________ Country: ______________

Subscriber: __________ Group # __________ Policy #: __________

Employer: ______________________________

SECONDARY INSURANCE INFORMATION

Insurance Company:

____

Address:

____

City: ____________ Country: ______________

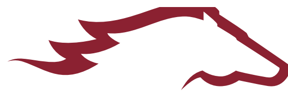
Subscriber: __________ Group # __________ Policy #: __________

Employer: ______________________________

I hereby confirm that all of the above information is true to the best of my knowledge and that my son/daughter is covered under the health insurance plan stated above.

Signature of Parent/Guardian: ______________________ **Date:** __________

Please attach copies of Insurance Policies or Insurance Cards



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LIABILITY RELEASE

Student's Name: ____
We hereby release Foxcroft Academy and all of its employees and host families from all liability, damages or claims which I have incurred after the termination of the program. We understand that, on occasion, students may choose to be transported by vehicles not operated by Foxcroft Academy and we hereby release Foxcroft Academy and all of its employees and host families from all associated liability.

We understand that the participant will be subject to the authorities and teachers of Foxcroft Academy and that he/she will have to follow the rules given by the family with whom he/she may live. We also understand that Foxcroft Academy reserves the right to terminate the participation in the boarding program of any participant whose conduct may be considered detrimental or incompatible with the interest and security of the boarding program. If this decision shall be enforced, the participant and his/her parents or legal guardians will be formally warned and have no right to any refunds.

The participant agrees to accept and uphold the standards of conduct set by Foxcroft Academy, and the family or families with whom he/she may live, for the duration of the program. He/she agrees to maintain friendly and respectful relations with his/her teachers and classmates and, especially, with all the members of the family with whom he/she may be living, to accept the rules of conduct imposed by said family, to participate in the family life as much as possible, to try his/her best to adjust to the normal system of family life and to treat all the members of the family with respect.

Signature of Student: ______________________________ Date: ____________

Signature of Parent: _______________________________ Date: ____________