

# Oakwood

F R I E N D S  S C H O O L

A Friends Coeducational Boarding and Day School  
22 Spackenkill Road, Poughkeepsie, NY 12603-5335 (800) 843-3341 (845) 462-4200 Fax (845) 462-4251  
[www.oakwoodfriends.org](http://www.oakwoodfriends.org)

# Important!

Dear Parents/Guardians,

Please read the attached forms carefully.

All students need to have a yearly physical exam, which includes a record of immunizations complete with month, day and year of the immunizations.

**All forms must be completed and on file before a student may begin school.**

If you have any questions, please call or email me.

Thank you for your cooperation.

Sincerely,

*Debbie Wilsey*

Debbie Wilsey  
Director of Health Services  
845 462 4200 ext.235  
[dwilsey@oakwoodfriends.org](mailto:dwilsey@oakwoodfriends.org)

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## Important!

Dear Parent or Guardian of all Oakwood Friends School Students:

Please read the attached forms carefully.

Below please find a complete breakdown of each element included in a complete record of all childhood immunizations. This is a New York State Department of Health requirement. I will identify any missing information for your child. Please provide the missing information to me as soon as possible.

A complete record of all childhood immunizations must contain:

- \_\_\_ 1) Student name and date of birth.
- \_\_\_ 2) The name and address of doctor filling out form, doctor must sign or provide their stamp.
- \_\_\_ 3) Record must indicate month, day, and year each vaccine was administered.
- \_\_\_ 4) Form must be filled out in ink and contain no whiteout. This is a legal document.
- \_\_\_ 5) Record Mumps-Measles-Rubella (MMR), Hepatitis B (Hep B), and Varicella (Chickenpox) must show one of the following:
  - specific date each vaccine in the series was given, or
  - you must provide a lab report showing the results of blood work (titer) if child had disease.

**All forms must be completed with an updated physical before a student may begin school.**

If you have any questions, please call or email me.

Thank you for your cooperation in this most important matter.

Sincerely,

*Debbie Wilsey*

Director of Health Services  
(845) 462-4200 ext. 235  
[dwilsey@oakwoodfriends.org](mailto:dwilsey@oakwoodfriends.org)

## ***PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION DRUGS***

State of New York school health regulations were written for public schools. The universal guideline is that a child suffering from any symptoms, including a headache or upset stomach, is to be sent home. Sending an Oakwood Friends student home in the event of a minor ailment is impractical. Therefore, we ask your cooperation in completing and returning the form below.

Name of Student (please print) \_\_\_\_\_

**I hereby give permission for Oakwood Friends School to dispense, under guidelines established by a physician, non-prescription medication for general ailments.**

### **PLEASE CROSS OFF THIS LIST ANYTHING YOUR CHILD MAY NOT HAVE**

Tylenol	for fever/pain/muscular aches
Advil	for pain/muscular aches/cramps
Maalox	for upset stomach/diarrhea
Benadryl	for allergy symptoms/allergic reaction
Cough syrup	for cough
Saline gargle	for sore throat
Throat lozenges	for sore throat
Ointments and lotions	for sore muscles, poison ivy
Medi-Phenyl (Phenylephrine 5mg)	Nasal Decongestant

### **ALL MEDICATIONS MUST BE CHECKED BY HEALTH SERVICES**

Are any prescription or non-prescription medications, or herbal supplements being used? Explain.

\_\_\_\_\_  
**SIGNATURE OF PARENT/GUARDIAN**

\_\_\_\_\_  
Date

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## Health History and Examination Form

Student's Name \_\_\_\_\_ Student's Birthdate \_\_\_\_\_

The above named student has been examined. The health history and immunization records have been reviewed. There are no apparent contraindications to participating in routine school activities [ ] (please check), or competitive sports [ ] (please check) and the physical exam is within normal limits [ ] (please check).

Special considerations, comments, etc.

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Height \_\_\_\_\_

Weight \_\_\_\_\_

BP \_\_\_\_\_

BMI \_\_\_\_\_

Scoliosis \_\_\_\_\_

Allergy \_\_\_\_\_

Physician: \_\_\_\_\_  
Print name

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Signature

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**THIS FORM MUST BE FILLED OUT BY DOCTOR**

STUDENT'S NAME \_\_\_\_\_ STUDENT'S BIRTHDATE \_\_\_\_\_

IMMUNIZATION RECORD

DATE GIVEN (MONTH/DAY/YEAR)

DTP 1	
DTP 2	
DTP 3	
DTP 4	
DTP 5	
TDAP	
OPV 1	
OPV 2	
OPV 3	
OPV 4	
MMR 1	
MMR 2	
HPV 1	
HPV 2	
HPV 3	
HEP A 1	
HEP A 2	
HEP B 1	
HEP B 2	
HEP B 3	
HEP B 3	
HIB 1	
HIB 2	
HIB 3	
HIB 4	
Varicella Disease	
Varicella (Chickenpox) #1	
#2	
T.B. Tine	
Meningococcal Vaccine	

Doctor's stamp with printed name and address goes here.

**To be filled out by doctor only**

## Residential School Meningococcal Vaccination Response Form

New York State Public Health Law requires that all parents or guardians of residential school students (or residential students 18 years of age and older) in grades 7-12, complete and return the following form to Oakwood Friends School.

**Check one box and sign below.**

My child has:

For students over the age of 18: I have:

- had the meningococcal meningitis immunization (Menomune<sup>®</sup>) within the past 10 years.  
Date received: \_\_\_\_\_

[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3 to 5 years.]

- read, or have had explained to me, the information regarding meningococcal meningitis disease. My child (I) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider.
- read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child (I) will **not** obtain immunization against meningococcal meningitis disease.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent / Guardian if student is a minor)

Print Student's Name \_\_\_\_\_ Student's \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of Birth

E-mail address \_\_\_\_\_ Student ID# \_\_\_\_\_

Mailing address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

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## MEDICATION REQUEST

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. School personnel are not responsible for any ill effects which might occur from this medication.

Persons who may assist your child with medications include the school nurse and trained campus staff. Parent/guardian must give a written request. The medication must be in the original container and properly labeled with student's first and last name. This is a state requirement.

NOTE: If the medication is a prescription, ask your pharmacist to prepare two labeled containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITON/ILLNESS MAY NOT BE GIVEN AT SCHOOL.**

**OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER.**

NAME OF STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_  
(on pharmacy label or hand written on a non-prescription container)

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE: (amount) \_\_\_\_\_

TIME TO BE GIVEN AT SCHOOL: \_\_\_\_\_

REASON OR HEALTH PROBLEM: \_\_\_\_\_

MEDICATION TO BE GIVEN FROM: \_\_\_\_\_ TO: \_\_\_\_\_

HOW IT IS TAKEN: \_\_\_\_\_  
(Example by mouth, by inhaler, with food or after meals)

WHEN WAS FIRST DOSE OF THIS MEDICATION GIVEN?: \_\_\_\_\_

\_\_\_\_\_  
PARENT'S/GUARDIAN SIGNATURE

\_\_\_\_\_  
DAYTIME PHONE

Reviewed by \_\_\_\_\_ Staff \_\_\_\_\_ may/ \_\_\_\_\_ may not administer

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
Signature

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**AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE  
AT SCHOOL AND AFTER-SCHOOL ACTIVITIES**

Board of Education policy permits a responsible, trained student to carry and/or self-administer medication for asthma (wheezing), severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principal approvals.

**PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER**

Name of Student \_\_\_\_\_ Date of Birth. \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Condition for which the medication is administered \_\_\_\_\_

Name of medication, dose and method administered \_\_\_\_\_

Time or indication for administration \_\_\_\_\_

Is this a controlled drug Yes \_\_\_\_\_ No \_\_\_\_\_

Side effects to be noted/reported \_\_\_\_\_

Other recommendations \_\_\_\_\_

Duration (dates) of administration: From \_\_\_\_\_ to \_\_\_\_\_ (limit of one school year)

**IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.**

\_\_\_\_\_  
Physician Signature      Print Name      Telephone      Date

**PARENT/GUARDIAN AUTHORIZATION**

I request that my child, named above, be permitted to: \_\_\_\_\_ carry \_\_\_\_\_ self administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original prescription; strength and dose of medication and directions for use. No more than a 45 school day supply of medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order.

\_\_\_\_\_  
Parent Signature      Date      Student Signature      Date

Parent Telephone Numbers \_\_\_\_\_

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

\_\_\_\_\_  
School Nurse Signature      Date      Principal Signature      Date

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REQUEST FOR EXEMPTION

Date \_\_\_\_\_

To the Director of Health at Oakwood Friends School:

As provided by Article 21, Sec. 2164(9) of the Public Health Law of the State of New York, it is required that my child be exempted from immunizations.

The reason for requesting this exemption is that such immunizations conflict with my religious beliefs, and with the teaching received by my child in the home, the church, and Sunday school.

Respectfully yours,

\_\_\_\_\_  
Name of Parent or guardian

\_\_\_\_\_  
My Child's Name

\_\_\_\_\_  
My Child's Date of Birth

\_\_\_\_\_  
My Address

\_\_\_\_\_  
My Telephone

**PERMISSION FOR MEDICAL/SURGICAL/DENTAL CARE**  
**Privacy Authorization Release Form**

I am the parent/guardian of \_\_\_\_\_  
(Student Name)

To the best of my knowledge this health history is correct, and the person herein described has permission to engage in all prescribed activities except as noted.

**Authorization for Treatment, Release of Information to Oakwood Friends School Personnel and Permission to Make Medical Appointments:** I hereby give permission for Oakwood Friends School personnel to order x-rays, routine tests and vaccines, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for my child in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by Oakwood Friends School to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of Oakwood Friends School.

STUDENT NAME (print) \_\_\_\_\_ STUDENT DATE OF BIRTH \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent/Guardian Cell \_\_\_\_\_

Bus. Phone – Parent/Guardian \_\_\_\_\_ Parent/Guardian Cell \_\_\_\_\_

Bus. Phone – Parent/Guardian \_\_\_\_\_ Student Cell Phone \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Name of Medical Insurance covering this child:** \_\_\_\_\_

Name of subscriber policy is under \_\_\_\_\_

Insurance Contract No. or I.D. No. \_\_\_\_\_

Date of Birth of Policyholder \_\_\_\_\_

Name of employer of subscriber \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_

Home address \_\_\_\_\_ Phone \_\_\_\_\_

Business address \_\_\_\_\_ Phone \_\_\_\_\_

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**ATTENTION: HOSPITAL/EMERGENCY ROOM PERSONNEL**

Please send all statements and other information to the parent named above, with duplicates to Oakwood Friends School.

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## Special Letter to Parents and Guardians of Boarders

Subject: Urgent medical care options and proof of insurance.

Dear Parents/Guardians of Boarders,

In the event of an illness or the need for urgent medical care, your child will be taken to our local Health Quest Immediate Care Center (Health QUICC) located in nearby Wappingers Falls or to Vassar Brothers Hospital in Poughkeepsie. In either case, the Health Office will need to present proof of insurance at the time of service. *Therefore, we must have a copy (front and back) of your Insurance and Prescription card.*

At Health QUICC no appointment is needed and timely, walk-in urgent medical care is available 7 days a week between the hours of 8:00AM and 10:00PM. If Health QUICC accepts your insurance, your child need only pay the required co-pay. Without insurance, full payment is expected at the time of service using cash, check, or credit card. An itemized bill will be given to the student.

If your child is not able to pay at the time of service, does not have health insurance or the need for care is outside the hours Health QUICC is open, your child will be taken to the Vassar Brothers Hospital emergency room for treatment. The hospital will bill the student or parent/guardian for the services rendered.

Please help us be better prepared when or if your child needs medical treatment. Please mail or fax copies of your medical cards to my office. Our fax number is (845) 462-4251. If you would prefer to speak to me directly regarding this issue my phone number is (845) 462-4200 ext.235.

Thank you for your time and attention to this matter.

Thank you,

*Debbie Wilsey*

Director of Health Services  
dwilsey@oakwoodfriends.org

List of insurance plans currently accepted by Health QUICC:

1199	Dutchess	Maxon	UnitedHEALTH
Aetna	County	MVP	Empire (UH)/NYSHIP
Beech St.	GHI PPO	National HA	WC
BC/BS	GHI HMO	Oxford	NF
CDPHP	HQ	POMCO	Other _____
Cigna	Local _____	SIEBA	