South Kent School

2011-2012

Student Health Forms for

_____

(please print student name)

Important: All students and their parents are required to fill out the following medical forms in their entirety and fax them to

1-888-803-0040

or mail them to the address below by July 15.

Dean of Student Affairs
South Kent School
40 Bulls Bridge Road
South Kent, CT 06785

SOUTH KENT SCHOOL

HEALTH SERVICES INFORMATION

Phone
Tel: 860-927-3539 Ext. 245

Hours
Richards Health Center
Monday – Friday 7:30 a.m. – 6:30 p.m.
Saturday 7:30 a.m. – 12:30 p.m.

Services
The School Physician, Dr. Bradford Harding, will hold office hours three times per week in the Health Center. The Director of Health Services has office hours Monday through Saturday. New Milford Hospital is located nearby.

Medical Files
Confidential student health information will not be shared without informed consent, unless it is necessary for the safety of the student. Disclosure of this information by the appropriate authorized school personnel may be indicated when it relates to the student's health maintenance, academic growth and/or social well-being.

Dear Parent/Guardian:

Welcome to South Kent School's Richards Health Center. This document contains the medical forms that need to be completed and mailed or faxed to the School prior to July 15. **Before a student may participate in any classes or sports activity, including early sports practice, his completed health forms must be received by the School. Each student must receive all of the required immunizations prior to his arrival at South Kent School.** This is a Connecticut State Law, not a South Kent School request. If you are sending copies of your child's immunization records, please attach these to our forms. These records must be in English. A date with the month and year must be indicated. A physical exam is also required every year. **Before a student may participate in any class or sports activity, including early sports practice, a consent form, a physician's physical examination form and an immunization record must be received by the School. Forms should be received by the School prior to a student's arrival on campus.** This information is strictly for the use of the Health Services at South Kent School and will be treated confidentially.

If you or your physician have any questions about the information contained in this document, please feel free to contact the Health Center at 860-927-3539 Ext. 245.

All students and their parents are required to fill out the following medical forms in their entirety and fax them to

1-888-803-0040

or mail them to the address below prior to arriving on campus.

Dean of Student Affairs
South Kent School
40 Bulls Bridge Road
South Kent, CT 06785

Part I
General Information: to be completed by the parent or guardian prior to a physician's physical examination of the student. Please include a recent photo of the student.

Part II
Personal Medical History: to be completed by the parent or guardian prior to a physician's physical examination of the student.

Part III
Physician's Physical Examination Form: to be completed by your physician. A physician's certificate will be acceptable, provided your physician supplies all requested information. If any illness, accident or hospitalization occurs after the physician's certificate has been completed and mailed to South Kent School, please notify the School immediately.

Please provide any general information or medical updates pertaining to your son. Please include all relevant information including dates, care provider name, address and phone number, diagnosis, testing/evaluation and summary of care.

SPECIAL NOTES:

- Any medication brought to school must be delivered to the Health Center, labeled with the student's name, and in Pharmacy /Manufacturer-labeled containers with dosage information and the physician's instructions. All vitamins, supplements and over-the-counter medications must be brought to and left with the Health Center personnel. **SELF-MEDICATION IS NOT PERMITTED.**

- The Authorization of Administration of Medication is included. This must be completed for each prescription the student is currently taking.

- Parents should arrange to have routine examinations (physicals, dental exams, etc.) completed during school vacations. It is not the responsibility of the Health Center staff to schedule routine medical/dental appointments for students.

- Flu vaccine will be offered and administered in the Health Center by the nurses and Dr. Harding, with a signed permission slip from the parent/guardian. Dr. Harding recommends that students with a history of asthma, diabetes, or any chronic illnesses which affect the body's resistance to infection receive the vaccine; otherwise, it is not necessary for a normally healthy adolescent. There is a fee for this vaccination.

- Any misstatement or falsification of, or material omission from, the Personal Medical History form may be grounds for South Kent School to require the student to withdraw.

- *Before a student may participate in any classes or sports activity, including early sports practice, all medical forms must be received by the School.*

Sincerely,

Debra Booth RN; BSN

Debra Booth R.N./BSN
Director of Health Services

SOUTH KENT SCHOOL

2011-2012 Health Forms

Consent Form – *This must be filled out by parent/guardian.*

I hereby grant permission to the staff or faculty of South Kent School to obtain for my child such emergency treatment or other medical care that they deem appropriate or necessary, and I authorize the school physician, presently Dr. Bradford Harding, to render to my child such emergency treatment or other medical care as he may deem appropriate. I also authorize treatment at or admission to a hospital if required. In an emergency situation when either parent or guardian cannot be reached, I grant permission to the Head of School (or his designee) to act and make decisions on behalf of the parents or guardian relating to medical care and treatment. In executing this agreement, I fully recognize that South Kent School shall not be liable in any way to me, the student or my family for any acts of omission or commission on the part of: (A) any individual acting as the school physician, and (B) any staff or faculty member of South Kent School. On behalf of myself and the student, I release South Kent School from any claim which I, he, or we might have against South Kent School, based upon the emergency treatment or medical care provided to or for the student.

In addition, I grant permission to South Kent School to release any medical records required for insurance purposes and to photocopy the appropriate forms for trips off campus. I give my permission for South Kent School to obtain medical records from other providers for treatment as necessary.

_____ _____

Date *Signature of Parent/Guardian of Student*

Student's Full Name: _____ Date of Birth:_____

Home Address:_____

Street *City* *State* *Zip Code* *Country*

Home Phone: ( ) _____ Fax: ( ) _____

Parent's name:_____

Business Phone Number: ( ) _____(Mother/Father) *circle one*

Mobile Phone Number: ( ) _____

Emergency Contact (other than Parent or Guardian):_____

Home Phone Number: ( ) _____Work Phone Number: ( ) _____

ALL U.S. STUDENTS MUST HAVE MEDICAL INSURANCE TO ATTEND SOUTH KENT SCHOOL

Primary Insurance Company:_____

Address:_____

Phone Number: ( ) _____HMO? (Yes/No) Is a referral needed? (Yes/No)

Insured's Name: _____

Policy Number: _____ Group Number:_____

ID Number:_____

PLEASE INCLUDE BACK AND FRONT COPIES OF ALL YOUR INSURANCE CARDS

***A MEDICAL INSURANCE POLICY IS OBTAINED FOR ALL INTERNATIONAL STUDENTS UPON THEIR ARRIVAL AT SOUTH KENT SCHOOL.**

List any Allergies (Medications/Food, etc.)_____

_____

List All Current Medications:_____

These must also be noted on the medication forms.

HIPAA Compliance

South Kent School is compliant with "HIPAA" rules and regulations. Medical information is held in strictest confidence with our medical staff.

However, there may be occasions when our medical staff needs to notify faculty members that a student will miss a school obligation because he/she is ill, has a medical issue or concern, or has an appointment with a specialist. Faculty may also be notified when a student's medical condition is serious enough that a medical leave of absence is necessary. Medical information is never disclosed, only the fact that there is an absence for a medical reason. In addition, our medical staff may also need to call an outside consultant to make a referral for a specialist on a student's behalf.

Thus, under the privacy regulations, we must have consent from parents to disclose the fact of student absences and necessary communication with off-campus health care providers.

Parents or guardians must sign the form at the bottom of this page for their son to enroll at South Kent School.

Use and Disclosure Covered by this Authorization

This form authorizes South Kent School's student health services staff, and affiliated health care providers under contract with the School which provide health care to students ("affiliated health care providers"), to use the student's health information, and disclose the student's health information to each other, for the following purposes: (1) to evaluate whether a medical leave of absence is appropriate as described in the Student Handbook, or (2) to evaluate whether to make an administrative request to initiate a non-disciplinary response to the student's use of alcohol or drugs as described in the Handbook, or (3) to evaluate whether accommodations at the School are recommended or necessary to address the student's health-related condition (such as, permission to miss a class while the student is receiving follow-up care from a physical therapist for a knee injury). This form also authorizes the student health services staff and affiliated health care providers to share the student's health information with School administration, faculty, dorm parents, and the Head of School to the extent necessary to make their recommendation about the situations described above. The student's health information that may be used or disclosed as described above includes information acquired by the student health services staff and affiliated health care providers when they provide health care to the student on campus. It also includes health information that is acquired by affiliated health care providers when they provide health care to the student off-campus, at their private practice offices or at a local hospital.

Specific Understandings

To the extent that the student's health information described above is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), it is called "protected health information." HIPAA requires that you be informed of the following before you sign this authorization form for the use and disclosure of protected health information.

By signing this authorization form, you authorize the use or disclosure of the student's protected health information as described above. This information may be redisclosed if the recipients described on this form are not required by law to protect the privacy of the information, and such information is no longer protected by the HIPAA privacy regulations.

You have a right to refuse to sign this authorization. The student's health care, payment for health care, and health care benefits will not be affected if you do not sign this form. However, the student's enrollment at the School is contingent upon this form being signed and remaining in effect.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the student health services staff, or affiliated health care providers, have already taken action based upon your authorization. However, the student's enrollment at the School is contingent upon this form being signed and remaining in effect. To revoke this authorization, please write to Fleur Vining in the Health Center. You have a right to receive a copy of this form after you have signed it.

Individual Authorization for Use/Disclosure of Health Information

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER YOU HAVE SIGNED IT.

I have read this Individual Authorization for Use/Disclosure of Health Information form, and all my questions about it have been answered. By signing below, I acknowledge that I have read and accept all of the information listed above under HIPPA Compliance.

Student's Name: _____ Date: _____
Printed

Signature of Parent/Guardian of Student: _____
(Required if student is under the age of 18)

Description of Parent/Guardian's relationship to student: _____
(eg. mother, father, grandparent, other guardian)

Signature of Student: _____

*Student name:*_____

Part I: General Information

To be completed by student's parent or guardian prior to completion of Physician's Physical Examination.

FAMILY AND/OR PRIMARY CARE PHYSICIAN

Name:_____

Address:_____
Street *City* *State* *Zip Code*

Phone Number: ( ) _____ Fax: ( ) _____

ANY PRESCRIBING PHYSICIAN

1. _____
2. _____
3. _____
4. _____
5. _____

OPTOMETRIST/OPHTHALMOLOGIST

Name:_____

Address:_____
Street *City* *State* *Zip Code*

Phone Number: ( ) _____Fax: ( ) _____

Date of last exam:_____

Does your son wear contact lenses?_____ glasses?_____

Vision: right eye:_____ left eye:_____

Please enclose a copy of eye glass/contact prescription with photocopies (front and back) of his Insurance Cards

Students are required to have a pair of regular eyeglasses with them even if they wear contact lenses.

DENTIST

Name:_____

Address:_____
Street *City* *State* *Zip Code*

Phone Number: ( ) _____Fax: ( ) _____

Date of last exam:_____ Is your son seeing an Orthodontist? (Yes/No)

*Student Name:*_____

ORTHODONTIST

Name:_____

Address:_____
Street *City* *State* *Zip Code*

Phone Number: ( ) _____Fax: ( ) _____

Date of last exam:_____

COUNSELOR OR THERAPIST

Name: _____ Phone: ( ) _____

Address: _____

Part II: Medical History

To be completed by student's parent or guardian prior to completion of Physician's Physical Examination.

FAMILY MEDICAL HISTORY

	Age	State of Health	Occupation	Medical History
Father				
Mother				
Brothers				
Sisters				

Has the student or immediate family had any exposure to Tuberculosis? _____

If either parent or siblings have died, at what age and from what cause?

_____

PERSONAL MEDICAL HISTORY
Has the student ever had problems with any of the following?

	Yes	No
Allergies: Medications		
Other		
Neurological: Seizures		
Headaches		
Vision Abnormalities		
Ear, Nose Throat		
Cardio-vascular: Heart Abnormalities		
Blood Pressure Problems		
Heart Rate Abnormalities		
Chest Pain		

Respiratory: Asthma/Hay Fever		
Recurrent Problems		
Genito-urinary		
Gastrointestinal		
Reproductive		
Musculoskeletal: Arthritis		
Chronic or Recurrent Injuries		
Skin: Eczema		
Seborrhea		
Psoriasis		

*Student Name:*_____

Please answer ALL questions with either "yes" or "no". All positive answers MUST be accompanied by additional information including dates of illness/surgery, copies of testing and summaries from care providers. Any misstatement or falsification of or material omission from the Personal Medical History may be grounds for South Kent School to require the student to withdraw.

A. Has the student had any significant illness or injury, or been hospitalized? _____

_____

B. Has the student undergone any surgical procedures? _____

_____

C. Has the student's physical activity been restricted during the past five years? If "yes", give details. _____

_____

D. Has the student received treatment or counseling for a nervous condition, personality or character disorder, psychiatric disorder, or emotional problem? If "yes", give details. _____

_____

_____

E. Does the student have any history of using substances (including alcohol)? If "yes", give details. _____

_____

_____

F. Has the student had difficulty with school, studies, or teachers? If "yes", give details. _____

_____

_____

G. Has the student ever been arrested? If "yes", give details. _____

_____

_____

H. Is the student currently taking any medication or supplements, (including over-the-counter medication)? Please list the medication, dosage, prescribing physician's name, address and phone number, and diagnosis. **Note: Self-medicating is not permitted at South Kent School**.

_____

_____

The above information is, to the best of my knowledge, true and correct. I understand that any falsification, misstatement, or omission of this information may be grounds for South Kent School to require my son to withdraw.

_____ _____

Date **Signature of Parent or Guardian**

_____ _____

Date **Signature of Physician** *Acknowledging Review*

Part III: Physician's Physical Examination

(MUST be filled out completely). A physical examination is required annually prior to registration.

Name:_____Birthdate:_____Age:_____

Height:_____ Weight:_____ Blood Pressure:_____ Pulse:_____

Please check whether normal or abnormal and elaborate, as necessary, on separate piece of paper:

	NORMAL	ABNORMAL
HEENT:		
Eyes, any correction? OD_____, OS_____, OU_____		
Lymph Nodes		
Thyroid		
Lungs		
Heart, any murmurs?		
Abdomen		
Genitalia		
Pulses		
Nervous System		
Extremities, articulations		
	NO	**YES**
Tonsils present?		
Any signs of endocrinopathy?		
Hernia?		
Scoliosis?		

Urinalysis.
Glucose:_____ Albumin:_____ Ketones:_____ Blood:_____

If albumin is positive or blood pressure elevated, Microscopic:_____

Hemoglobin/HCT:_____

Do you find this student capable of participating in unlimited competitive athletics and recreational activities?
Yes:_____ No:_____ Limitations:_____

Please list the names and dosages of any medications that the student will be taking while at school, and the names of prescribing doctors.

Medications:_____

Allergies:_____

Major Illnesses/Health History:_____

_____

Physician:_____ Address:_____

Date of Exam:_____ Phone Number:_____

*Student Name:*_____ Date of Birth:_____

IMMUNIZATIONS

State of Connecticut Public Act 78-165 requires that each child be properly immunized; the following immunizations are required for attendance at school in the State of Connecticut. Proof of immunization is a signed document by a physician with the list of the DATES OF ALL IMMUNIZATIONS, or a photocopy of your son's immunization record.

Non-compliance with Public Act 78-165 is permissible only for medical or religious reasons. For medical exemption, it is necessary that a physician provide a signed statement. For religious exemption, a statement from the parents or guardian that such immunization would be contrary to the child's religious beliefs is necessary.

Connecticut State Law also requires that a second measles vaccine be administered at the time of entrance into the seventh grade. Therefore, South Kent School requires that all students have a Measles Booster immunization before entering South Kent School. If immunization to measles, mumps or rubella has been deferred because of having had the disease(s), proof of immunity by laboratory test is also required from the examining physician. Please have this attended to, if needed, prior to arrival at South Kent School.

Required Immunizations:

1. Diphtheria, Pertussis, Tetanus (DPT): 4 doses (the last dose must be given on or after the 4th birthday) Adult Td may be substituted for DPT when a child is age 7 or older.
2. Trivalent Oral Polio Vaccine (TOPV) OR Inactivated Polio Vaccine (IPV): 3 doses (The last dose must be given on or after the 4th birthday).
3. Measles, Mumps, Rubella (MMR): 2 doses
4. A PPD test for Tuberculosis (TB): prior to entrance to South Kent School. If positive, results of chest x-ray required.
5. Hepatitis B: 3 doses or proof of serologic evidence of previous infection with Hepatitis B.
6. Varicella vaccine or documentation of year student had chicken pox disease.
7. Meningitis Vaccine

Please enter Immunization Dates

DTap:	#1_____	#2_____	#3_____	#4_____	#5_____
Polio:	#1_____	#2_____	#3_____	#4_____	
Td/dT: (every 10 yrs)	#1_____				
MMR:	#1_____	#2_____			
		OR			
Measles: (2 doses)	#1_____	#2_____			
(proof of blood titer required if records are unavailable) _____					
Mumps:	#1_____	#2_____			
Rubella:	#1_____	#2_____			
Hepatitis B:	#1_____	#2_____	#3_____		
Varicella Vaccine:	#1_____	#2_____	or Date of Illness: _____		
Meningococcal Vaccine:	#1_____	*Or waiver to be provided.			

Tuberculin Test – PPD required for every student within one year prior to entrance (regardless of BCG), or if positive test prior.

TB Skin Test (PPD):	Date: _____	Results: _____ mm induration
If positive skin test, X-ray required:	Date: _____	Results: _____
Medication: _____	Date started: _____	Duration: _____
Has the student received BCG?	Circle YES or NO Date: _____	

_____ _____

Date Signature of Physician

Clinic Stamp

Address / Phone Number of Clinic: _____

SOUTH KENT SCHOOL

Request Authorization for Administration of Medication by School Personnel

(Please copy and use one form for each medication)

The Connecticut State Law requires physician/dentist/APRN/PA's written order and the parent and/or guardian's authorization for a nurse to administer medications or, in his/her absence, the principal and/or designated staff to administer medications. Medications must be in pharmacy-prepared containers and labeled with the name of student, name of drug, strength, dosage, frequency, name of physician/dentist/APRN/PA, date of original prescription.

PHYSICIAN/DENTIST/APRN/PA ORDER

Name of Student_____Date_____

Address_____D.O.B._____

Condition for which the drug is to be administered _____

Drug (name, dose, and method of administration)_____

_____

Time of administration_____

Medication shall be administered from:_____ to:_____

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

_____

(Signature)_____M.D.

……

Authorization by parent/guardian for the administration of the above medication by school personnel:

To School Personnel:

I request that the above medication ordered by the physician/dentist/APRN/PA for my child _____, be administered by school personnel. I understand that I must supply the school with prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name:_____

Signature:_____ Relationship to child:_____

Phone:_____Date:_____

General Statutes, Section 10-212a, Connecticut State Department of Health, PHN Division

SOUTH KENT SCHOOL

Medication Transport

Due to the legal ramifications relating to student transport of medications, controlled medications will not be given to students to transport to and from home, or other destinations, unless the form below has been checked and signed by you.

Student's Name:_____

Please check **one** of the options listed below:

❑ 1. Please mail my son's medications home at the beginning of vacations. I will mail them back to the School. I understand that I will be assessed a fee for this service.

❑ 2. Please give my son's medications directly into the care of a Parent or Guardian.

❑ 3. My son has my knowledge and permission to transport his medications to and from school. I assume all liability associated with this action.

_____ _____

Print Student Name Signature of Student

_____ _____

Print Parent or Guardian Name Signature of Parent or Guardian

Date: _____

SOUTH KENT SCHOOL

Influenza Vaccine 2011-2012

Anyone interested in receiving the influenza vaccine must sign a permission slip, and any parents wishing their son to have the vaccine must also submit a signed permission slip. Everyone receiving the vaccine will be required to wait in the Health Center for a full 20 minutes afterwards to insure that there is no allergic reaction. ***Please review the following page of this document.***

Dr. Bradford Harding recommends that students with a history of asthma, diabetes, or any chronic illnesses which affect the body's resistance to infection receive the vaccine; otherwise it is not necessary for a normally healthy adolescent.

There will be an additional charge to the family/student account. South Kent School will bill you for this.

It is recommended to each person who requests vaccination that appropriate consultation be sought from that person's physician who is best able to render an individualized medical judgment. Every effort has been made to provide such patients, parents, and/or guardians meaningful information relating to the risks and benefits of vaccination in form and language understandable by all concerned.

INFORMATION ON PERSON TO RECEIVE VACCINE

Name:_____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Telephone: ( ) _____

_____
Signature of person to receive vaccine (if 18 or over) or signature of parent/guardian

_____
Date

For Clinic Use Only

Clinic Site:_____ **Date Vaccinated:**_____

Manufacturer and Lot Number:_____
Vaccination Site: **( ) Left Arm** **( ) Right** Arm

IMPORTANT INFORMATION ABOUT INFLUENZA VACCINE 2011-2012

What is influenza ("FLU")? It is an illness caused by influenza viruses. It can affect people of all ages. Usually, people with influenza have abrupt onset of fever, chills, headache, sore throat, cough, and muscle aches and may be sick for several days to a week or so. Most people recover fully. A small proportion of cases are particularly severe, and patients may develop pneumonia or other complications. The risk of complication and death from influenza is highest for people with chronic health problems like diabetes, diseases of the heart, lung, and kidneys, severe anemia, or chronic illnesses (or medications) which lower the body's resistance to infections. In general, it is also high for older persons, particularly those 65 years or older. Tobacco smokers are also at higher risk.

Influenza viruses frequently undergo changes in their chemical makeup. These changes make it possible to catch influenza even though immunity (antibodies) may have been developed against previous strains of influenza. Thus, having had influenza or influenza vaccine in past years may not prevent one from getting influenza again. Influenza epidemics are unpredictable. However, some influenza cases occur each year.

Influenza Vaccine: Influenza vaccine is composed of killed influenza viruses and is given by injection. The vaccine will not protect all persons against the flu. It also will not protect against other illnesses that resemble the flu.

Possible side effects from the vaccine: Most people will have no side effects from the influenza vaccine. Some persons may complain of a sore arm for 1 to 2 days. Fever, chills, headaches, and muscle aches might occur 6 to 12 hours after vaccination and persist for 1 to 2 days. As with any drug or vaccine, there is a possibility that allergic or more serious reactions, such as paralysis and even death, could occur. **THE VACCINE CANNOT CAUSE INFLUENZA. RESPIRATORY ILLNESS OCCURING AFTER BEING VACCINATED IS COINCIDENTAL AND UNRELATED TO THE VACCINATION.**

THE FOLLOWING PERSONS SHOULD NOT BE VACCINATED:

Those who have allergies to eggs or thimerosal
Those who have had a previous severe allergic reaction to or other problem with the vaccine
Those who have a fever or feel ill with something more than a cold
Those with an active neurological disorder

QUESTIONS: If you have any questions about influenza or influenza vaccination, please ask now, or call your physician or local Department of Health before requesting the vaccine.

REACTIONS: Anyone receiving influenza vaccine who becomes ill and visits his physician, hospital, or clinic in the four weeks after this vaccination, should report this illness to Progressive Medicine at 860-269-7011.

SOUTH KENT SCHOOL

Prescription Medications

South Kent offers families two options for managing student prescriptions.

GroupRx
The school and GroupRx are working together with families to have their medicines pre-Packaged in individual dose packets. GroupRx is the pharmacy which will dispense your son's medication on a daily or as needed basis and is in full compliance with State and Federal laws. Each medication your son takes will be dispensed by our pharmacy and packaged, sealed and sorted according to Day and Time of administration. This includes prescription, non-prescription (OTC) items, and vitamins. All medication will be shipped to school prior to your son's arrival and billed directly to your insurance company. You will be responsible for a one time registration fee of $24.50 for the school year and a $12.50 monthly administration fee, which includes the cost of packaging and shipping all of your son's medications to school. OTC/Sundry items, medication costs not covered by Insurance as well as any co-payments/deductibles will be billed to your credit card account on file. Emergency orders may require express overnight shipping fees. GroupRx will send medication packets home for use during extended vacation periods for an additional $12.95 per shipment.

On-line registration will be available after July 1, 2011 and will take you through the process. Please register at least 30 days prior to the start of school to avoid late charges associated with rush service. If you need any assistance, please contact GroupRx at: (877) 230-6030 or by email to support@grouprx.net.

Kent Apothecary
Kent Apothecary is pleased to provide daily service to South Kent School for the 2011-2012 academic year. To provide Kent Apothecary with your son's current information, the following page must be completed and mailed or faxed to South Kent's Health Center. These forms must be completed EVERY SCHOOL YEAR. Please also include a photocopy (front and back) of your PRESCRIPTION insurance card. Kent Apothecary accepts most insurance plans and will make every effort to become an active participant in any plan in which they are not currently enrolled. These forms must be completed each year so Kent Apothecary's files can be updated with the new insurance/credit card information.

Please keep in mind that many employers change insurance plans or carriers throughout the course of the year. It is in everyone's best interests that Kent Apothecary is made aware of these changes so that there will be no interruptions or problems with billing prescriptions for your child. Failure to provide current insurance coverage will result in the pharmacy charging full retail price.

We recognize the school's policy on outside medications being brought to the infirmary and offer a fee-based repackaging service if required. If you have any prescriptions on hand that your son will need filled or repackaged, please deliver them to the school infirmary, and we will coordinate the actual dispensing with them.

We require that you provide your credit card information so that we may charge any prescription co-pays and/or over-the-counter items directly to you. Please make sure that the card you provide is valid throughout the entire school year. All information is kept confidential and secure. As with insurance cards, please keep the pharmacy informed of any credit card changes to ensure that we maintain proper and efficient billing information.

Please contact Peter D'Aprile at Kent Apothecary with any questions concerning billing, insurance or medications. He can be reached by phone at 860-927-3725 or by e-mail at peter@kentapothecary.com.

Kent Apothecary • 3 Maple Street• P.O. Box 672 • Kent, CT 06757 • Phone: (860) 927-3725

** Please Print All Information Clearly **

SECTION I: STUDENT INFORMATION

Student Name (last, first, MI):		Date of Birth:	
Social Security Number:		Phone:	
Allergies to Meds:			

SECTION II: PARENT/GUARDIAN INFORMATION

Name (last, first, MI):		Home Phone:	
Billing Street Address:		Cell Phone:	
P.O. Box		Work Phone:	
City:		Fax Number:	
State & ZIP Code:		Email:	

SECTION III: CREDIT CARD INFORMATION ** (REQUIRED) **

Method of Payment:	❑ VISA ❑American Express ❑Mastercard ❑Discover
Name of Student:	
Credit Card Number:	
Credit Card Expiration Date:	
Name (as it appears on card):	
Signature authorizing payment:	

Please check ALL Applicable:

❑ I have enclosed a copy (Front & Back) of my son's PRESCRIPTION insurance card

❑ My son has School Insurance

❑ My son has NO PRESCRIPTION INSURANCE Coverage

_____

❑ I authorize my son to charge over-the-counter products to the above card.

Kent Apothecary is covered by the medical information privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (generally called "HIPAA") and its Regulations. As a result, we are required to comply with HIPAA and the Regulations in the use and disclosure of health information by which our patients can be individually identified. We are also required under Section 164.520 to give our patients this notice (in paper or electronically as the patient wishes) of our legal duties and privacy practices concerning their Protected Health Information, and also to tell our patients about their rights under HIPAA and the Regulations. If you have any questions about our policies, please contact us directly. We are required by this Act to request your signature upon receipt of this document. Please sign your first and last name clearly on the line below. If your child is 18 or older, he may sign as an adult.

I have received a copy of the Kent Apothecary Privacy Notice.

Signature: _____ Date: _____

I authorize the release of my medical/prescription information to my parent/guardian (For students over 18 years of age):

Signature: _____ Date: _____