Dear Parents and Guardians,

We look forward to starting a new school year at Good Hope Country Day School with you and your children! Here you will find a list of required medical documents for the start of the 2022-2023 school year. I encourage you to schedule your child's wellness check-up for this summer as soon as possible. If you have any questions regarding the requirements for school attendance please contact the School Nurse at ccooper@ghcds.org

Physical Exam/Wellness Exam Record: To be completed by your child's physician.

- **Due annually for all students in Nursery through Senior year,** as recommended by the American Academy of Pediatrics and required by the USVI Department of Human Services.
- If your student will be participating in Sports or After School Activities, your doctor will need to complete a preparticipation physical exam and submit the Medical Eligibility Form.

Official Immunization Record

- Must be on file on or before the first day of school. In accordance with USVI law, students will not be permitted to attend school until this requirement is met. Please see the CDC vaccine schedule.
  - **The following immunizations are required for school entry in the USVI:** Hepatitis B, Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Varicella, and Meningococcal. An annual flu vaccine is strongly encouraged.
  - **Parents of 11 year olds:** The first dose of the Meningococcal conjugate vaccine (MCV4) and a booster dose of Tdap is due at this age. The HPV vaccine is optional but encouraged. Please see this Vaccines for Preteens and Teens: What Parents Should Know fact sheet for more information.
  - **Parents of 16-18 year olds**: The second dose of Meningococcal conjugate vaccine (MCV4) is due at this age.
- If your child has a medical or religious exemption from vaccination, a vaccine exemption form from the Department of Health must be submitted on or before the first day of school. Please see The Department of Health's Procedure for Immunization Exemptions for further details.

Parent Permissions Form:

- To be completed by guardians. You will find this form attached with the physical exam.

If applicable:

- Prescription Medication Release Form: Signed by a parent **and physician.**

- **Emergency Action Plans (EAP) from a Physician (For asthma, allergies, etc.) The below listed action plans are simply suggestions, your doctor will decide which EAP is best for your child.**
    - **AAP Allergy and Anaphylaxis Emergency Plan**
    - **AAP Asthma Action Plan**

Good Hope Country Day School
Physical Examination Report

Name _____ Age____ Date of Birth_____ Grade_____

It is mandated by the VI Department of Health that this completed physical exam form and a copy of an Official immunization card be on file before or on the first day of school. Annual physical exams are required of all students. Emergency action plans must be completed by your child's physician for any allergies listed and submitted by the first day of school.

This Page to Be Completed by Student's Physician or Qualified Medical Professional:

Physical Exam:

Weight: _____ Height: _____Blood Pressure & Pulse:_____ General Appearance:_____
Posture_____ Eyes: _____ Snellen Test: R) _____ L) _____ Wears Glasses: YES NO
Ears: _____ Teeth: _____ Nose & Throat: _____ Thyroid_____Abdomen: _____
Heart: _____Lungs:_____Skin: _____Hernia: _____Musculo-skeletal: _____

Medical Conditions:

Chronic Medical Conditions/Related Surgeries *List medical conditions & ongoing surgical concerns	( ) None ( ) Care Plan Attached	Comments:
Medications/Treatments *List medications/Treatments	( ) None ( ) Yes, please list	Comments:
Limitations to Physical Activity *List limitations/special considerations	( ) None ( ) Care Plan Attached	Comments:
Special Equipment Needs *List items needed for daily activities	( ) None ( ) Care Plan Attached	Comments:
Allergies/Sensitivities *List allergies (medications, insects, foods, other)	( ) None ( ) **Emergency Action Plan Attached**	Allergy to: Reaction Hx:
Special Diet *List dietary specifications	( ) None ( ) Care Plan Attached	Comments:
This student has developmental, emotional, behavioral, and/or a psychiatric condition that may affect their educational experience	( ) None ( ) Yes; _____ ( ) IEP attached	Comments:

Result of physical examination normal? YES NO Abnormalities Noted: _____

Any Conditions needing treatment during the school year? (If not explained above) _____

Examining Practitioner: *Please review student's immunizations. If immunization exempt, please refer to DOH for clearance.*
( ) All immunizations are up to date. OR ( ) A Catch-up schedule for immunizations has been initiated.

( ) I have examined the child listed above and reviewed their health history. It is my opinion that they are medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.
( ) **I have found this child to be free of communicable diseases**.

Physician Name: (Print) _____ Phone # of HCP: _____
Physician Signature: _____ Date: _____
Practice/Clinic Name: _____ Address:_____

Good Hope Country Day School

For Parent/Guardians:

Student Full Name: _____ Date of Birth:_____ Grade:_____

I give consent for my child's Health Care Provider & GHCDS Nurse to discuss information included in the Physical Exam Report, all submitted medical documents including immunizations, and any future medical conditions that may arise during the school year.

Parent/Guardian Signature: _____ Date_____

In the event that my child suffers an accident or other medical emergency, I authorize trained medical personnel to provide emergency treatment (including epinephrine administration) and/or transportation to a hospital or other medical facility. I understand the school will make every effort to contact me, but by my signature below I authorize treatment and/or transportation as necessary for the health and safety of my child.

_____ _____

Parent/Guardian Signature Date

I hereby grant my permission for the Good Hope Country Day School Nurse or other delegated School Personnel to administer non-prescription, over-the-counter medication(s) on an as needed basis to my child during the school day. No over-the-counter medications will be given to students under the age of 6 unless directed by a doctor.

( ) Yes, my child can have the following **circled medications** at school *in addition to antibiotic ointment for minor injuries, sunscreen, and bug spray.*

Acetaminophen **Ibuprofen** **Cough Drops** **Benadryl**

Cough Syrup **Daytime Cold relief** **Tums/Pepto**

( ) No, my child cannot have OTC medications at school with the exception of antiseptic wash and antibiotic ointment in the event of a minor injury at school.

Parent Signature: _____ Parent Printed Name:_____

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

Good Hope Country Day School

Request for Medication Administration by School Personnel

Dear Parent/Guardian:

When the physician decides it is necessary for your child to receive a medication during the school day, his/her approval and specific directions must be provided to the school.

- Medication must be brought to school by a parent/guardian and delivered to the School Nurse or school personnel along with this form completed by the Physician prior to the first scheduled dose during attendance at GHCDS.
- The medication must be in a container appropriately labeled by a pharmacist or physician.
- Labels must include:
  - Name of student
  - Name of medication and Dosage
  - Time to be given
  - Physician's name
- To protect your child and other students, medication may not be kept with the student unless specified by the student's doctor.
- Students are expected to come to the Nurse's Office at the appropriate time to take medication.

Both parent and physician signatures are required to permit the nurse, or any non-medical person authorized by the school in the event the nurse is not available, to administer the medication listed below.

THIS FORM MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN AND THE PARENT FOR PRESCRIPTION MEDICATION TO BE TAKEN IN SCHOOL AND EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR.

_____ _____ _____

Name of student **Birth Date** **Grade level**

_____ _____ _____

Medication **Dosage** **Time to be given at school**

Stop Date:_____

Diagnosis/Reason for taking medication:

Possible Side Effects and Action to be taken:

I have read and agree with the above medication policy.

_____ _____

Physician signature Print Date

_____ _____

Parent/Guardian signature Print Date

( ) *I give consent for my child's Health Care Provider & GHCDS School Nurse to discuss information on this form.*