BROADWATER ACADEMY MEDICAL INFORMATION PACKET

Student Information

First Name: ____________________
Middle Name: ____________________
Last Name: ____________________
Date of Birth: ____________________

Doctor / Hospital Information

Doctor: ____________________
Phone: ____________________
Address: ____________________
Date of Last Physical Exam: ____________________
Hospital: ____________________

Student Blood Type (optional field):
⚪A+ ⚪A- ⚪AB+ ⚪AB- ⚪B+ ⚪B- ⚪O+ ⚪O-

Dentist Information

Dentist: ____________________
Phone: ____________________
Address: ____________________
Date of Last Dental Exam: ____________________

Insurance Information

Insurance Company: ____________________
Policy Number: ____________________
Group: ____________________

Permission to Treat

If the parent(s)/guardian(s) are unable to be reached in an emergency, I give Broadwater Academy permission to transport my child to the nearest medical facility via ambulance and to call my child's physician/healthcare provider and follow his/her orders.

○ Yes ○ No

Medical / Health Conditions

Does the student have any medical / health conditions? (If yes, please list below)

○ Yes ○ No

Conditions:

____

____

____

Please list all known Allergies: Food, Drug, Seasonal, etc. Please include the reaction including anaphylaxis if applicable.

Allergies ○ Yes ○ No

If Yes, Describe below and submit Food Allergy & Anaphylaxis Emergency Care Plan and Medication Consent forms to school nurse (may be found on resource page):

____

____

____

Glasses ○ Yes ○ No

Contacts ○ Yes ○ No

Wears them Full Time ○ Yes ○ No

Wears them for Distance ○ Yes ○ No

Wears them for Reading ○ Yes ○ No

Asthma ◯Yes ◯No

If Yes, Describe & Submit Asthma Action Plan & Medication Consent Forms to school nurse (may be found on resource page):

Chicken Pox / Mononucleosis ◯Yes ◯No

If Yes, Describe:

Diabetes ◯Yes ◯No

If Yes, Describe & Submit Diabetes Medical Management Plan & Medication Consent Forms to school nurse:

Ear Infections / Hearing Problems ◯Yes ◯No

If Yes, Describe:

Seizures / Fainting ◯Yes ◯No

If Yes, Describe & Submit Epilepsy Seizure Action Plan & Medication Consent Forms to school nurse (may be found on resource page):

Fractures / Dislocations / Sprains ◯Yes ◯No

If Yes, Describe:

Frequent Headaches / Migraines ◯Yes ◯No

If Yes, Describe:

Heart Conditions / Murmurs ◯ Yes ◯ No
If Yes, Describe:

Kidney or Urination Problems ◯ Yes ◯ No
If Yes, Describe:

Major Head / Neck / Back Injury ◯ Yes ◯ No
If Yes, Describe:

Psychological / Emotional / Behavioral Concerns ◯ Yes ◯ No
If Yes, Describe:

Respiratory Infections / Conditions ◯ Yes ◯ No
If Yes, Describe:

Bleeding Problems ◯ Yes ◯ No
If Yes, Describe:

Skin Problems / Rashes ◯ Yes ◯ No
If Yes, Describe:

Stomach / Bowel Problems ◯ Yes ◯ No
If Yes, Describe:

Throat Problems ◯Yes ◯No
If Yes, Describe:

___

___

Eye / Vision Problems ◯Yes ◯No
If Yes, Describe:

___

___

Other Medical Conditions Not Listed Above ◯Yes ◯No
If Yes, Describe:

___

___

Has the student received any immunizations within the last year? ◯Yes ◯No

Please provide the school nurse with updated immunization records.
Please list most recent immunizations:

___

___

Has the student been seen by an MD or in the ER in the past 3 months for non well-child visits?
◯Yes ◯No

If Yes, Describe:

___

___

History of Hospitalizations / Operations?
◯Yes ◯No

If Yes, Describe:

___

___

Does the student have any chronic, physical problems, pertinent developmental information, or special accommodations needed?

⚪Yes ⚪No

If Yes, Describe and submit any prior paperwork to school nurse (504 plan, etc.):

____

____

May the above information be shared with appropriate school staff, if the school nurse deems it necessary?

⚪Yes ⚪No

If only certain information may be shared, please describe:

____

____

Over The Counter Medications

I give permission for qualified school personnel to administer the following medications according to the manufacturer's instructions on Broadwater Academy school grounds or designated school field trips. I hereby acknowledge that I have read and understood the Broadwater Academy policies related to taking medications. I hereby release Broadwater Academy and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify,defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with a licensed healthcare provider. Broadwater Academy will keep the following medications below in the school nurse office to administer as over-the-counter medication when approved by a parent/guardian by clicking "yes" below. If a parent/guardian would like to send their own over-the-counter medication to be stored in the school nurse office, it must be delivered to the school nurse by the parent/guardian in an unopened, sealed box/container and original packaging from the store/pharmacy. All Pre-K students will need one separate MAT Medication Consent Form to be filled out for each over-the-counter medication listed below (or any others sent by parent) per student as required by the Department of Social Services. If parent/guardian selects "no" below, qualified school personnel will not be able to give the medications listed below on school grounds or field trips.

If the parent/guardian would like to be contacted before or after administering a specific over-the-counter medication, please state below.

Medication	Yes	No	Need to Contact Before or After Administration? (Write Yes or No or Leave Blank if No)
A&D Ointment/Cream:	◯ Yes	◯ No	____________________
Acetaminophen:	◯ Yes	◯ No	____________________
Aloe Vera:	◯ Yes	◯ No	____________________
Bacitracin Zinc:	◯ Yes	◯ No	____________________
Benzalkonium Chloride:	◯ Yes	◯ No	____________________
Calamine Lotion/Spray/Gel:	◯ Yes	◯ No	____________________
Cough Drops:	◯ Yes	◯ No	____________________
Diphenhydramine:	◯ Yes	◯ No	____________________
Eye Drops:	◯ Yes	◯ No	____________________
First Aid Burn Cream/Gel:	◯ Yes	◯ No	____________________
Hand/Body Lotion/Cream:	◯ Yes	◯ No	____________________
Hydrocortisone:	◯ Yes	◯ No	____________________
Hydrogen Peroxide:	◯ Yes	◯ No	____________________
Ibuprofen:	◯ Yes	◯ No	____________________
Insect Repellent:	◯ Yes	◯ No	____________________
Isopropyl Alcohol:	◯ Yes	◯ No	____________________
Lidocaine:	◯ Yes	◯ No	____________________
Lip Moisturizer/Ointment:	◯ Yes	◯ No	____________________
Povidone-Iodine:	◯ Yes	◯ No	____________________
Saline Solution:	◯ Yes	◯ No	____________________
Sting Relief Pad/Wipe:	◯ Yes	◯ No	____________________
Sunscreen:	◯ Yes	◯ No	____________________
Triple Antibiotic Ointment: (Bacitracin Zinc, Neomycin Sulfate, Polymyxin B Sulfate)	◯ Yes	◯ No	____________________
White Petrolatum/Vaseline:	◯ Yes	◯ No	____________________

Medications Taken by Student

Please list ALL medications the student takes at home or during the day on a regular basis, including over-the-counter and prescription medications. For Pre-K students, we will need a separate MAT Medication Consent Form for each over-the-counter or prescription medication to be administered at school (Healthcare provider must also sign this form for prescription, rescue medication, over-the-counter medication needed more than 10 days or when instructions say "consult a physician"). For Kindergarten through 12th grade students, we will need a separate Medication Consent Form for each prescription medication or over-the-counter medication to be given to students during the school day (Healthcare provider must sign for prescriptions or OTC

medication given above recommended dose on bottle). All medications must be stored in the school nurse office, unless the student has written consent from a healthcare provider for them to self-carry rescue medications. All medications stored in the school nurse office must be delivered to the school nurse by a parent/guardian in the prescription bottle with all identifying information on the label or in an unopened/sealed over-the-counter box or container in original packaging. If a student needs to take a new type of medication after this form has been submitted, the parent/guardian must provide the nurse with the appropriate medication consent forms along with the medication.

Does the student take any prescribed or over-the-counter medications on a regular basis?

◯ Yes ◯ No

If medication is given at school, may school personnel give things like crackers, applesauce, pudding, or apple juice with the medication?

◯ Yes ◯ No

Describe if restrictions with food or drink that should / should not be used:

____

____

Medication #1: ________________________________
Dose: ________________________________
Route: ________________________________
Self Administer: ◯ Yes ◯ No
Date Prescribed: ________________________________
Discontinued: ◯ Yes ◯ No
Daily Schedule: ◯ Yes ◯ No
Notes: ________________________________

Medication #2: ________________________________
Dose: ________________________________
Route: ________________________________
Self Administer: ◯ Yes ◯ No
Date Prescribed: ________________________________
Discontinued: ◯ Yes ◯ No
Daily Schedule: ◯ Yes ◯ No
Notes: ________________________________

Medication #3: ________________________________
Dose: ________________________________
Route: ________________________________
Self Administer: ◯ Yes ◯ No

Date Prescribed: ____
Discontinued: ◯ Yes ◯ No
Daily Schedule: ◯ Yes ◯ No
Notes: ____

Medication #4: ____
Dose: ____
Route: ____
Self Administer: ◯ Yes ◯ No
Date Prescribed: ____
Discontinued: ◯ Yes ◯ No
Daily Schedule: ◯ Yes ◯ No
Notes: _______________________________________

Medical Forms Due

ALL MEDICAL FORMS ARE DUE ON OR BEFORE AUGUST 19. We encourage you to submit them as soon as possible. You may go to the Broadwater Academy website to find links for all of the medical forms within the Medical Information section. Forms may be faxed, emailed, mailed, or given in person to the school nurse.

If you are unsure whether we have your child's health records on file, please contact Kim Coates at the location listed below.

Kim Coates, RN, BSN
Director of Nursing / School Nurse
Broadwater Academy
3500 Broadwater Road, P.O. Box 546
Exmore, VA 23350
757-442-9041 x123 work
757-442-9615 fax
kcoates@broadwateracademy.org
www.broadwateracademy.org

Agreements

Broadwater Academy agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if requested by Broadwater Academy. If the student drives themself to school, the parent/guardian will confirm if the student is able to drive themself home if they are sick.

The parent(s)/guardian(s) agree to inform Broadwater Academy within 24 hours or the next business day after their child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases, which must be reported immediately.

We/I give permission for the school nurse to communicate with my child's healthcare provider and/or Virginia Department of Health regarding pertinent health information.

⚪Yes ⚪No

Parent/Guardian Signature:

Name: ______________________________ Date: ____________

Signature: ____________________________________

My signature below affirms that all of the information contained in this Medical Information Packet is correct, complete, and honestly presented. I understand that withholding or misrepresenting information in this packet may jeopardize my child's / student's enrollment.

Parent/Guardian Signature:

Name: ______________________________ Date: ____________

Signature: ____