



## 2018-19 STUDENT INFORMATION FORM

*To be completed for events where SEA staff are the primary caretakers of students*

**Student name:** \_\_\_\_\_ **SEA member program:** \_\_\_\_\_

**Student cell phone:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

No student cell phone

**Parent/Guardian 1 name:** \_\_\_\_\_

**Parent/Guardian 2 name:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Cell phone #: \_\_\_\_\_

Cell phone #: \_\_\_\_\_

Home phone #: \_\_\_\_\_

Home phone #: \_\_\_\_\_

Work phone #: \_\_\_\_\_

Work phone #: \_\_\_\_\_

**Home address:** \_\_\_\_\_

Street & Apt

City, State

Zip Code

**Emergency contact:** If parents/guardian cannot be reached, please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary health care provider** (doctor's name): \_\_\_\_\_

Name of clinic/office: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Street & Apt

City, State

Zip Code

**Health insurance** company or policy name: \_\_\_\_\_  No insurance

Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Does your child have **allergies**? **YES**      **NO**

If yes, please describe: \_\_\_\_\_

Does your child have **any medical conditions** and/or regularly take **medication(s)**? **YES**      **NO**

If yes, please describe: \_\_\_\_\_

\*\* Please note that **if your child needs to take medication at while in SEA care**, you must:

- Provide written authorization for SEA to administer medication to your child (see page 3)
- Send the medication in the original container

## SEA 2018 - 2019 STUDENT HEALTH FORM

To be completed by a physician or nurse practitioner. This form may be substituted by submitting both (1) a list of immunizations from a doctor's office and (2) a copy of a physical examination completed within the past 18 months detailing medications, allergies and/or dietary restrictions, past medical treatments, and any physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while in the program.

Student full name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address (street, city, state): \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

**Students are required to be immunized with the following. Please list specific dates for all immunizations or attach a form from the physician with this information.**

Diphtheria, Tetanus, Pertussis (DTaP/DTP/DT/Td) (5): \_\_\_\_\_

Td/Tdap for grade 7 (age 12) thru college\* (1): \_\_\_\_\_ Tetanus/diphtheria (td) Booster: \_\_\_\_\_

\* Everyone else is required to have a dose of Tdap/Td if it has been more than 10 years since the previous dose of Td.

Polio (OPV/e-IPV) (4): \_\_\_\_\_  
3 doses are acceptable if the 3<sup>rd</sup> dose is given on or after the 4<sup>th</sup> birthday and  $\geq 6$  months after the previous dose.

MMR (2): \_\_\_\_\_ OR Laboratory evidence of immunity

Hepatitis B (3): \_\_\_\_\_ OR Laboratory evidence of immunity

Varicella vaccine (2): \_\_\_\_\_ OR – healthcare provider certified history of chickenpox disease.

**Date of last complete physical exam:** \_\_\_\_\_ (must be within 18 months of SEA event)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Hct. or Hgb.: \_\_\_\_\_ TB test \_\_\_\_\_

Any significant illness or injuries since last physical exam? \_\_\_\_\_

General estimate of health: \_\_\_\_\_

Please list **medications** to be administered out while participating (including over-the-counter drugs):

\_\_\_\_\_

Please list **allergies and/or health conditions** such as asthma, etc., which may affect the student's activities:

\_\_\_\_\_

Name of health care provider: \_\_\_\_\_

Address of health care provider: \_\_\_\_\_

Health care provider phone: \_\_\_\_\_

**Signature of examining physician/nurse practitioner:** \_\_\_\_\_

## Authorization for the Administration of Medication by SEA Program Personnel

Parents/guardians requesting medication administration to their child must provide the appropriate written authorization(s) before any medications are administered. Medication prescribed for participants must be kept in original containers bearing the pharmacy label, which shows the date of filing, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescription, and if tablets or capsules, the number in the container. All over-the-counter medications for participants must be kept in the original containers containing the original label, which shall include the directions for use. Participants may only take medication when it is administered by the health supervisor or a licensed healthcare professional.

### Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug? **YES NO**

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time of Administration \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements \_\_\_\_\_

Specific Instructions for Medication Administration: \_\_\_\_\_

Medication Administration: Start Date \_\_\_/\_\_\_/\_\_\_ Stop Date \_\_\_/\_\_\_/\_\_\_

Specific Precautions: \_\_\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Known Food or Drug Allergies? **YES NO** Reactions to? **YES NO** Interactions with? **YES NO**

If "yes" to any of the above, please explain \_\_\_\_\_

Diagnosis (at parents' discretion) \_\_\_\_\_

Name of Licensed Prescriber \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Licensed Prescriber's Address \_\_\_\_\_

### Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of SEA Activity/Event \_\_\_\_\_ Dates of Event: \_\_\_\_\_

Child's Address \_\_\_\_\_ City, State \_\_\_\_\_

Name of Guardian Authorizing Administration of Medication \_\_\_\_\_

Relationship to Child (circle): Mother Father Other (explain): \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

➤ **Signature of Parent/Guardian Authorizing Administration of Medication** \_\_\_\_\_

\*\*\*\*\*

### Name of program personnel receiving written authorization and medication [FOR PROGRAM USE]

\_\_\_\_\_  
Name & Title/Position

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date