Bridgeport International Academy

State of Connecticut Health Requirements

The Academy highly recommends that you purchase International Health Insurance, as medical costs in the USA are very expensive should your child need to visit the clinic or hospital.

The following health criteria must be met in order to register a child in a Connecticut school:

1. **Physical health exam and completion of the three-page Health Assessment Record Form (HAR-3).** Connecticut State Law requires this for **ALL** new students prior to school entrance. It must be completed after June 1st in the enrollment year and presented to the Academy **before** admittance. Parents fill out and sign Part I (page 1) and a qualified physician fills out and signs Part II (page 2) as well as fills out and signs the Immunization Record (page 3).

2. **Required Immunizations must be translated into English:**
   - **DPT or DTa/Td:** at least three doses. Last dose must be given on or after the 4th birthday.
   - **Polio:** at least three doses. Last dose must be given after 4th birthday.
   - **Measles, Mumps & Rubella Vaccine (MMR)**: two doses – one dose on or after the 1st birthday and the second dose must be given at least four weeks after the first dose.
   - **Hepatitis B:** three doses (this is a series).
   - **Varicella Vaccine**: one dose given on or after the 1st birthday, or two doses if the second dose is after the 13th birthday. If your child has had chicken pox, then a physician must verify this in writing.
   - **Tuberculosis Test:** required for **all** international students or students who have recently lived abroad.
   - **Meningitis Vaccine:** one dose **highly** recommended for students living in a group/dormitory setting. Optional but suggested for all other students.

3. If your child requires the administration of any medical preparations, including all over-the-counter medications, during school hours, a physician's written order and parent/guardian authorization is required. Please complete the form entitled "Authorization for Administration of Medicines."

4. It is imperative that a parent/guardian contacts the school nurse if a child is allergic to insect bites or has any severe allergies.

5. The following online site provides excellent information in many languages regarding immunizations: http://www.immunize.org/vis/vis_english.asp

If you have any questions or concerns about your child's health, please do not hesitate to contact the school nurse.

285 Lafayette Street, Suite 200 Bridgeport, CT 06604
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State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take in school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ______________________ Birth Date ____________ Date of Exam ____________

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal
Neurologic		
HEENT		
*Gross Dental		
Lymphatic		
Heart		
Lungs		
Abdomen		
Genitalia/ hernia		
Skin		

Ortho	Normal	Describe Abnormal
Neck		
Shoulders		
Arms/Hands		
Hips		
Knees		
Feet/Ankles		

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
Lead:	
*HCT/HGB:	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan to School
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: ______________________

Daily Medications (*specify*): ______________________

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: ______________________

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: ____________

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above ____________________ (Specify) ____________________ (Date) ____________________ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _________ Recertify Date _________ Recertify Date _________

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6

DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12

Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Bridgeport International Academy

Consent to Medical Emergency Treatment or Hospitalization

I hereby affirm my responsibility to assure that proper medical services be provided at all times to ___________________________________. I hereby authorize Bridgeport International Academy or the Academy's physician or nurse, if any, to provide or authorize medical attention by their parties to the student requested above. In case of emergency Bridgeport International Academy is to exercise for me, on my behalf, all my rights and duties with reference to consenting to appropriate medical surgical services including hospitalization which may deem necessary for emergency care of the student. I appoint Bridgeport International Academy my true and lawful attorney in fact for me in my name, place, stead, to sign my and all necessary documentation to provide the medical services to the student, and such signature will be in my name. I understand that Bridgeport International Academy shall not be responsible for the payment of fees or charges. The Academy will accept billing in my name only to facilitate submission of student accident insurance claims, if applicable, or for the prompt forwarding of billing to me. I further understand that Bridgeport International Academy assumes and has no responsibility for the provision or authorization of medical services to the student. I waive all claims that may arise in connection with any such medical attention.

I hereby acknowledge and confirm that this form is intended to protect the health and welfare of the above named student.

I certify that I have read, understood, and have the right and authority to execute the "Consent to Emergency Medical Treatment".

IN WITNESS WHEROF, I have here unto set my hand and seal the year and day first below written.

____ ___________________________

Printed Name of Parent or Guardian Date month / day / year

____

Signature of Parent or Guardian

Complete address of parent or guardian ____

____

Phone Number ___________________________ E-mail address: ___________________________________

Insurance Information

Insurance Company: ___________________________ Policy Number: ______________________________

Policy Holder Name: ___________________________cial Security Number: __________________________

Employer's name and address: ____

____

____

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Bridgeport International Academy

General Authorization and Release Form

We, (individually or jointly) as parent/legal guardian of ________________________, agree to the following:

1. That we have enrolled the above named student at Bridgeport international Academy (hereafter the Academy) and hereby hold harmless, discharge. We release the Academy from all liability for injury, loss, damage, obligation, expense, or penalty sustained by the above named student arising out of or in connection with the above named student's participation at the Academy.

2. That we authorize the Academy or the Academy's physician or nurse, if any, to provide or authorize medical care for the above named student as needed or requested. In case of emergency, the Academy is authorized to consent to appropriate medical and surgical services it deems necessary. We accept full responsibility for all costs of the medical care or emergency treatments. The Academy will not be responsible for the payments of any medical care or emergency treatment but will accept billing in its name only to facilitate submission of medical insurance claims for the above named student, if applicable, or for the prompt forwarding of bills to me/us.

3. That we agree that the Academy will not be liable for authorizing medical treatment for the above named student pursuant to my/our authorization (in paragraph #2 above) and waive all claims whatsoever in connection with such medical treatments. We agree that the Academy will not be liable for and agree to hold the Academy harmless from any liabilities, losses, injuries, damages, or expenses related to the above named student's participation in any of the activities at the Academy and form the student's enrollment at the Academy generally. Any and all claims against the Academy are waived. Any damage and harm caused by the above named student will be the responsibility of the parent/legal guardian.

4. That we authorize the above named student to participate in any of the Academy's sponsored or related activities, trips, or excursions, whether held on Academy grounds or otherwise, including recreational, educational and cultural activities and trips to other cities and states.

5. That we agree, if the Academy incurs legal fees and expenses in connection with the enforcement of this "General Release and Authorization" to pay or reimburse the Academy for all such reasonable costs within thirty (30) days after receiving written notice of such charges.

6. That we certify that we have read, understood, and have the right authority to execute this "General Authorization and Release".

____

Printed name of Parent or Guardian

____ ____________________________

Parent or Guardian Signature Date

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Bridgeport International Academy

Medical Administration Policy

Full name of student: ____

The school has a clear policy regarding the administration of prescription medications and non-prescription medications. When a student is required to take medications, parents should contact the school nurse to determine which category applies.

Type I: Ordinary Prescription Medications

Prescription medications are generally administered at the Academy's health center. However, with permission from the school nurse, certain medications may be self-administered in the dormitory. Examples of these are antibiotic ointments and cleansers for acne, inhalers for asthma, and certain allergy medications. Prescriptions which are approved by the Health Center to be self-administered must be in their original containers, with the form entitled "Permission to give Medication at School" filled out by the prescribing physician and on file in the Health Office. Students may not be sent antibiotics or other prescription medications from home to keep in dorm rooms. All medications must be screened by the Health Office.

Type II: Federally Controlled Substances

These medications must be stored and administered at the Health Center. Controlled substances such as, but not limited to, Adderall, Dexedrine, Ritalin, Fiorinal, and Tylenol #3 (with Codeine) are not allowed in the dormitories nor may they be self-administered. Medication such as anti-anxiety, behavior, and sleeping pills are also not allowed.

Type III: Over-the-Counter Medication

Over-the-counter (OTC) medications such as Advil, Tylenol, antacids, cough, and cold medications should not be kept in the dormitories unless previously approved or provided by the Health Office. This is so, to prevent self-treatment by the student which may lead to delayed care in more serious conditions (for example: bronchitis, pneumonia, and strep). Vitamins and supplements may be kept by students in the form only when the nurse is notified. A form to give medication is not needed for vitamins. Permission from parents to give OCT's is needed before any medications can be given. The school physician has written Standing Orders for Advil, Tylenol, Robitussin, Sudafed, and Pepto-Bismol and their generic forms. These may be given with written permission of parents/guardians.

I, ______________________________, give my permission to BIA school nurse and designated school officials to give over-the-counter medications as ordered by the school physician to ____ (please print name of student).

Please list any exceptions in giving these over-the-counter medications: ____________________

____

____ ____________________________

Signature of Parent or Guardian Date month / day / year

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Bridgeport International Academy

Authorization for the Administration of Medicines by School Personnel

Name of Student: ______________________ DOB: __________ Grade: ________
Known Allergies: ____

Connecticut State Law Requires:

1. The written order of an MD, OD, DDS, APRN, or a PA for prescription and non-prescription medications.
2. Written authorization from the parent/guardian for medications, prescription, and non-prescription, to be administered by school personnel.
3. Medication must be received and stored in the original container.
4. All medication, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent/guardian or other responsible adult.
5. No more than a 45 day supply of medication may be left at school.
6. Inhalant medications may be self-administered at all grade levels with the approval of the school nurse.
7. Self-administration must be authorized by the MD or authorized prescriber and parent/guardian.

<u>This portion to be completed by Parent or Legal Guardian</u>

I hereby give permission for my child to receive the medication ordered by a licensed prescriber, recognized by the State of Connecticut. Medication is to be administered by:

__________ School Nurse, Teacher or principal, trained in the administration of the medication.
__________ Child may self-administer with approval of licensed prescriber and school Nurse.

Please check:
I request the medication be administered on shortened school days: ☐ yes ☐ no
I request the medication be administered on field trips: ☐ yes ☐ no

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school, whichever comes first.

Signature of Parent/Guardian ______________________ Home Phone: ____________
Date: ______________________ Work Phone: ______________________

<u>This portion to be completed by the Physician/Licensed Prescriber ONLY</u>

Name of Medication: ______________________ Dosage: ____________
Route of Administration: ______________________ Frequency: ____________
Time to be given in School: ______________ Start date: ________ Stop Date: ________
Reason for Medication: ____
Side Effect and Plan for Management: ________________________________
Special Instructions: ____
____
Is this medication a sample? ____
Is the student capable of self-administering? ______________________________
Permission to gibe in school if failed to receive dose at home? ______________________
Physician or Authorized Prescriber: ________________________________
(please print or type clearly)

Address:
____

Phone: ______________________ Fax: ______________________

Signature: ______________________________ Date: ______________

PLEASE NOTE: Signature must be in ink – Rubber stamped orders will not be accepted. A separate form must be used for each medicine. This form, if utilized, must be signed and returned to the Health office.

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Bridgeport International Academy

Exemption Form

Student's full name: ______________________________ Date of Birth: _____________

Statement of Exemption to Immunization Law: Medical Exemption

The physical condition of the above named student is such that immunizations would endanger the student's life or health. Please indicate what immunizations and the reason for exemption:

____

____

____

____

Temporary ☐ **Permanent** ☐

Individual exempted from receiving immunizations because of medical contraindications shall be reviewed every six (6) months to determine whether such medical contraindications still apply.

Physician's signature _______________________________ Date: ___________________

Student's full name: ______________________________ Date of Birth: _____________

Statement of Exemption to Immunization Law: Religious Exemption

The above named student adheres to a religious belief whose teachings are opposed to the above immunizations.

Parent or Guardian signature _________________________ Date: ________________

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