

**Welcome to The Georgetown Prep Health
Office Website**

You will find all forms that your son needs to start school for proper health clearance. Every student needs the following forms:

***Medical Information Form**

***Insurance/Health History Form**

***Physical Exam Form (must be completed by MD)**

***Immunization Form**

***HIPPA/Over the Counter Med Form**

If your son takes a medication regularly, you must fill out the “Long-Term Medication Form”. There is one section for day students, followed by a section for resident students. All the forms needed are found in each section. Please read through each section completely to fill out ALL of the necessary forms.

We check the mail during the summer, so feel free to mail back your forms early. However, we must have all forms by August 1st. Have a relaxing summer and we will see you in September.

Sharon Weldon, R.N. and Kathy Kitzinger, R.N.

GEORGETOWN PREP
HEALTH OFFICE REQUIREMENTS FOR DAY STUDENTS
2006-2007

1. **STUDENT MEDICAL INFORMATION FORM**

Students are required to have a yearly physical exam with their primary doctor prior to returning to school in September. The accompanying Medical Information Form must be completed by both the physician and parent and returned to school before July 31, 2006. Please be honest in indicating all previous and current medical issues, limitations to school activities, or allergies. This information is extremely important for us to have on file in the event of an emergency. This form also requests emergency contact numbers that are important for obvious reasons. Please update our files during the school year if phone numbers change.

2. **IMMUNIZATION HISTORY**

Prep uses the Maryland State Immunization Form to obtain this part of each student's medical history. You will be happy to hear that this form needs to be filled out only one time in your four-year stay at Prep. The form can be updated as immunizations are added. Please let us know of any additions. Please fill out this portion of the form carefully because the Health Department reviews them thoroughly each fall, particularly the freshmen records. The minimum required immunizations are as follows:

--3 DTP and 1 Td (4 total)

--3 Polio

--2 MMR—the first must be given after the child's first birthday or it is invalid and needs to be repeated.

--3 Hepatitis B

--Varicella vaccine or date of chicken pox disease

3. **MEDICATION**

The nurse must dispense any prescription medication that needs to be taken during the school day. This refers to all medications including those for A.D.D./A.D.H.D. This is a Maryland State Law. A Long Term Prescription Form must be filled out, signed, and on file in the Health Office for any ongoing medication by the first day of school. Parents must bring the medication to the Health Office, properly labeled with the correct dose and time of administration.

The Health Office has some over the counter medications available for student use during the school day, such as Tylenol, Ibuprofen, Pepto-Bismol, Sudafed, and other over the counter medications. Legally, we are unable to dispense them without your written permission.

4. SCHOOL INSURANCE

All students are enrolled in a generic student insurance that covers ONLY accidents and injuries occurring during school sponsored functions. Please contact us about filing a claim. Otherwise, it is your responsibility to have individual medical insurance for your son.

5. HEALTH OFFICE

The Health Office is located on the second floor of Boland Hall. The office is staffed by the nurse between the hours of 7:30 A.M.—3:30 P.M. Monday through Friday. Please feel free to contact us with any questions or concerns during these hours.

*phone number/ voice mail:

301-214-1235

*Fax number:

301-214-8602

*e-mail:

Sharonw@gprep.org

kkitzinger@gprep.org

Have a great summer! Looking forward to a healthy school year.

Mrs. Weldon
Mrs. Kitzinger

2006-2007
MEDICAL INFORMATION FORM
GEORGETOWN PREPARATORY SCHOOL
10900 ROCKVILLE PIKE
NORTH BETHESDA, MD 20852
HEALTH OFFICE: 301-214-1235 FAX: 301-214-8602

The information on this page is used by the administration to assist in obtaining medical care and for contacting parents in the event of a medical emergency. This form may also accompany the student on off-campus events.

Last Name	First Name	M.I.	Date of Birth
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Address _____

Grade _____ Day Student _____ Resident _____

PERMISSION FOR EMERGENCY TREATMENT

In the event parents or legal guardians named on this form cannot be contacted, I the undersigned do hereby authorize the officials of Georgetown Preparatory School to obtain emergency medical treatment for the health of _____.

Print Student's Name

I will not hold the school responsible for the emergency care and or transportation for said student.

Signed: _____ Date: _____

EMERGENCY CONTACT PHONE NUMBERS

Physician: _____ Phone Number: _____

Mother: _____ Home Phone: _____

E-Mail: _____ Work Phone: _____

Cell Phone: _____

Father: _____ Home Phone: _____

E-Mail: _____ Work Phone: _____

Cell Phone: _____

Back Up: _____ Home Phone: _____

Contact Person Work Phone: _____

Cell Phone : _____

TO BE COMPLETED BY PARENT

INSURANCE INFORMATION

Day students, please include a copy of the card or fill out the below information thoroughly. You **MUST** include your insurance information.

Primary Insured's Name: _____ DOB: _____
SS#: _____
Health Insurance Name: _____
Type: (HMO, PPO, ETC.) _____
Policy Number: _____
Group Number: _____

BRIEF HEALTH HISTORY

TO BE COMPLETED BY THE PARENT

Please comment on any areas that may affect your son's participation in school and sports activities or would be significant information for emergency services.

Allergies to Medications: _____ Type of Reaction: _____
Allergies to Foods, Insects, etc.: _____ Type of Reaction: _____
Airborne Allergies: _____ Treatment: _____
Asthma: _____ Treatment: _____
Diabetes: _____ Treatment: _____
Cardiac Problems: _____ Treatment: _____
Kidney Problems: _____ Treatment: _____
Migraine Headaches: _____ Treatment: _____
Any recent or significant joint problems: _____
Any other medical concerns: _____
Any special requests: _____

2006-2007
TO BE COMPLETED AND SIGNED BY PHYSICIAN

PHYSICAL EXAM FORM

Last Name _____ First Name _____ M.I. _____

Significant Medical History:

Date Of Physical Exam: _____ (Must be within 12 months of the start of school.)

Most Recent PPD Result/Date: _____

Height: _____ Weight: _____ BP: _____ P: _____

This exam was completely normal. YES NO (Please explain below)

Restrictions to participation in school NO YES (Please explain below)
or sports activities.

Current Medications:

Additional comments:

The above named student has my permission to receive over the counter medications: acetaminophen, pseudophedrine, ibuprofen, robitussin, pepto-bismol, loratidine, tums, antibiotic ointment, hydrocortisone cream. Please cross out any medication not allowed.

Physician Signature (Required): _____ Date: _____

Physician Name Printed: _____

Physician Address: _____

Physician Phone: _____

GEORGETOWN PREP

REQUIRES PARENT SIGNATURE

**CONFIDENTIALITY OF MEDICAL INFORMATION
NEW HIPPA GUIDELINES**

Georgetown Preparatory School and Health Office are being asked to comply with some new national requirements regarding confidentiality of medical information. This is known as the HIPPA or Health Information Portability and Accountability Act. This act has many purposes and components, but there is one aspect that relates specifically to the students in a school situation. This component is the “privacy rule” that ensures privacy and confidentiality of all personal medical information.

Because of these new guidelines, the Prep Health Office requests your permission to discuss health issues with physicians and to submit pertinent health insurance claims related to medical problems that may arise during the school year. Also, health issues that may affect a student’s ability to function in the classroom may be discussed with the appropriate personnel.

I have read and understand the above information regarding HIPPA regulations and agree to allow the Prep Health Office to share and submit health information for my child as deemed necessary.

Name of Student: _____

Date: _____

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

OVER THE COUNTER MEDICATIONS

In the course of assessment and treatment of student medical problems, it is occasionally appropriate to administer Tylenol (acetaminophen), Sudafed (pseudoephedrine), Advil (ibuprofen), Robitussin, Pepto-Bismol, Claritin, and other over the counter medications.

My son _____ may/may not receive these over the counter medications when it is deemed appropriate by the Health Office.

Parent/Guardian Signature _____ Date: _____

LONG TERM PRESCRIPTION MEDICATION FORM

Long-term medication may be given, provided that the prescribing physician and parent complete the following permission request form.

Bring the medication in the original prescription bottle, properly labeled by a registered pharmacist, as prescribed by law.

NAME OF STUDENT: _____

DATE OF BIRTH: _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Name of Medication: _____

Dose(s) to be given at school: _____

Time(s) to be given at school: _____

Other instructions: _____

Side Effects: _____

Effective From: _____ Until: _____

Please indicate any activity restrictions: _____

Signature of Physician _____ **Date** _____

To Be Completed By Parent:

My child has permission to receive the above medication as directed.

Parent/Guardian Signature: _____ **Date:** _____

The school cannot accept responsibility for students taking prescription medicine during the school day without the supervision of the school nurse. For this reason, no student may possess or take prescription medicine during the day without the supervision of the school nurse.

In an effort to ensure the safety of your son and other students, any student found in possession of a controlled substance will be in violation of a school rule and will be subject to the consequences entailed by such an offense.

Georgetown Preparatory School

Athletic Consent Form

Student Name: _____ Grade: _____
Sport(s): _____

By signing below, I/We certify that:

PARENTAL CONSENT TO TREAT:

- A. Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer, Staff, and coaches to proceed with any necessary primary and secondary first aid. In the event of serious illness or injury I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event that I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant is given.

- B. Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer to proceed with the necessary evaluation, minor medical treatment, and/or rehabilitation for the above-named student/athlete.

- C. Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer to proceed with the necessary use of modalities (i.e. ice, moist heat, ultra sound, electric stimulation) for the care, treatment, and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the orders of the Georgetown Prep Team Physician and will only be administered by the Georgetown Prep Athletic Trainer.

CONSENT TO RECEIVE MEDICATION:

Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer to distribute medication (listed below) to the above-named student/athlete. Please indicate if your son should not have any of the following medications that may be available in the athletic training room for athletes.

- | | |
|---------------------------------|--|
| Acetaminophen (generic 200 mg) | Pepto-Bismol |
| Benadryl (25) | Cepacol Throat Lozenges |
| Ibuprofen (200) | Epi-Pen (0.3 mg provided by physician) |
| Pseudoephedrine (generic 30 mg) | Bio-Freeze (analgesic balm) |
| Bacitracin | Athletes Foot Cream/Spray Powder |
| Hydrocortisone Cream 1.0% | Sterile Saline Solution/Eye Wash |
| Hydrogen Peroxide | Betadine Solution |

The above-named student/athlete should not take, is allergic to, the following: _____

STATEMENT OF RISK:

I acknowledge that Georgetown Preparatory School assumes no responsibility for any risks associated with voluntary participation in school-organized athletics, physical education or other activities. Furthermore, I understand that these sports involve risk of serious injury or death. After weighing these risks against the potential benefits my son may gain from these activities, I freely and fully accept the risks of athletics on my child's behalf.

I acknowledge that Georgetown Preparatory has the right to terminate treatment if the student is non-compliant with the treatment plan that is proposed by the school trainer.

I acknowledge that Georgetown Preparatory School is not responsible for providing ongoing care for injuries related to non-school sports.

STATEMENT OF LIABILITY:

In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse, or my son against Georgetown Preparatory School and its employees arising from a sports related injury or from transportation to/from a sporting event.

Carrier: _____

Policy Number: _____

Physician: (Name and Telephone No.) _____

Emergency Contacts: (Name and Telephone No.) _____

SIGNED _____ DATE _____

RESIDENT STUDENT HEALTH INFORMATION
PLEASE READ CAREFULLY

1. THE HEALTH OFFICE

The School Health Office is located on the second floor of Boland Hall. The office is staffed by the nurse between the hours of 7:30 A.M.- 3:30 P.M. Monday through Friday to dispense medications and evaluate illnesses and injuries. Any student health needs after these hours should be brought to the attention of the Residential Dean or prefects on duty. The nurse and doctor are available for consult 24 hours a day.

Morning "Sick Call" occurs between 7:30 A.M.- 8:00 A.M. Monday through Friday. This is the time that resident students see the nurse if they feel they are ill and unable to go to school that day. A determination is made as to whether the student will attend all or part of the day's classes. Students MUST see the nurse before missing any class. Oversleeping and fatigue are not considered excusable absences!

Afternoon "Sick Call" is between 3:00 P.M. – 3:30 P.M. Monday through Friday. This time is used to handle any illnesses or injuries that have occurred during the school day.

2. MEDICAL INFORMATION FORM

This is the mandatory form that asks for current medical history, immunization history, insurance information, and permission to treat your son in an event of an emergency. You will find all this included in this packet. A yearly physical exam is mandatory. A copy of your insurance card is also mandatory. This form is especially important for resident students to have on file here for obvious reasons. Please return this to us as soon as possible.

*****YOUR SON WILL NOT BE ALLOWED TO STAY IN THE
DORMS OR ATTEND SCHOOL IF ALL THIS INFORMATION IS
NOT ON FILE BY THE TIME HE ARRIVES IN AUGUST!!!**

This rule will be strictly enforced!!

3. IMMUNIZATION AND HEALTH FORM REQUIREMENTS

Georgetown Prep follows the Maryland state requirements for immunizations. Please fill out this portion of the form carefully, because the Montgomery County Health Department reviews them thoroughly in the fall of each year. If your son's form is not on file at the time of the inspection, he will be removed from the school until the form is submitted. We have begun using a separate Maryland State Immunization form. This

form needs to be filled out only once during the student's four year stay at Prep and can be updated as new immunizations are given. Please inform us of any additions. The minimum required immunizations are as follows:

- 3 DTP and 1 Td
- 3 Polio
- 2 MMR (measles, mumps, rubella—first dose must have been administered after the first birthday)
- 3 Hepatitis B
- Varicella vaccine or date of chicken pox disease
- Meningococcal vaccine

Resident students are required to have a recent PPD (tuberculosis test) on file with the health office. Any positive readings must be accompanied by an explanation of the results and the treatment given.

At this time Hepatitis B and meningococcal immunizations are not required and are the decision of the student and his physician. We strongly recommend both of these immunizations due to the close living quarters in a dorm.

Prep also requires each student to have a yearly physical exam with his primary physician. There is a portion of the Medical Information Form, which should be filled out by the physician. Another portion is filled out by the parents. Please be honest in indicating all previous and current medical issues, allergies, and limitations to school activities. As stated above, this form must be on file prior to the start of the school year. All information is confidential.

4. **INSURANCE COVERAGE: RESIDENT STUDENTS MUST SUBMIT PROOF OF HEALTH INSURANCE.**

All students in the school are enrolled in a generic student school insurance that covers **ONLY** accidents and injuries occurring during school sponsored functions. Please be aware that it does **NOT** cover personal, off campus events, hospitalizations or emergency room visits for other reasons such as illness, etc. Because of this we are requiring that all resident students have some type of additional medical insurance beyond the student insurance.

If you have private health insurance for your son that is pertinent to this area of the country (e.g. Blue Cross/Blue Shield, etc.) and would like us to use it while he is at Prep, please include the actual medical card or a copy of both sides of the card when returning his medical information. You may need to research whether the insurance you have can be used in the Washington Metro area. If you do not already have health insurance for your son, then you must purchase additional insurance and must provide us with a copy of the front and back of this card. Please contact the business office if you need information about international student medical insurance plans.

5. YOUR PRIVATE PRESCRIPTION COVERAGE

As with your health insurance, if you have prescription coverage for your son that you would like us to use, please include a card or copy of a card with his health form. Georgetown Prep uses the White Flint Pharmacy for all prescriptions. (301-881-3828). It is your responsibility to check with the pharmacy to find out if your current health insurance is accepted. Otherwise, you may be responsible for paying full price for any medications needed during the school year.

6. MEDICATION

The Health Office provides some over-the-counter medication for resident students to use such as Tylenol, ibuprofen, Sudafed, Benedryl, Pepto Bismol, and Claritin. If you would like your son to be able to receive these medications during the school year, you must fill out and sign the part of the health form that gives us permission. We are legally unable to give out these medications without a signed consent form. The students are allowed to keep some over the counter medications in their rooms with the permission of the Health Office. All prescription medications must be discussed with the nurse. Any prescription that is controlled or monitored MUST be kept in, and administered from the nurse's office. This is a Maryland state law and there are NO exceptions. Included in this are medications used for ADD/ADHD. A parent must bring the medication to the Health Office immediately upon arrival at school. You also have the option of mailing the medication to the Health Office, or you may mail the written prescription to us to be filled. **MEDICATION MAY NOT BE GIVEN TO THE STUDENT TO BRING TO THE HEALTH OFFICE. Please be aware that if you give us the prescription to fill, you must include a method of payment.** Any long-term prescription medication that is used during the school year must be on file with the nurse. Please indicate on the "Long-Term Medication Form" how you plan on having this medication refilled throughout the school year. A "Long-Term Medication Form" is provided for this purpose.

7. PHYSICIAN COVERAGE

Georgetown Prep has a physician that visits the Health Office twice a week to see any resident students that may require more in depth medical care. Dr. Thomas McNamara sees students, identified by the nurse, on Monday and Thursday mornings between 8:00 A.M.-8:30 A.M. There are no additional charges for these visits. He is always available to be reached at any time by the nurse for concerns about student health issues.

8. OUTSIDE MEDICAL APPOINTMENTS

If your son develops a medical condition that is beyond the scope of our ability at Prep, he may be referred to an outside specialist in the area. This is one reason that we request information about your private health insurance. We will attempt to follow the guidelines of your insurance in setting up this appointment. The school will make arrangements for these appointments if they are urgent medical problems ONLY. Students are responsible for any bills related to these visits. Also, the Health Office will not be responsible for routine medical appointments during the school year.

Please feel free to contact the Health Office at any time to discuss issues or concerns you may have about your son. We will contact you with any serious health issues that may arise. As always, we are looking forward to a healthy and safe school year.

Sharon Weldon, R.N.
School Nurse
Kathy Kitzinger, R.N.
School Nurse—Part-Time

--phone number / voice mail 301-214-1235
--e-mail address Sharonw@gprep.org, kkitzinger@gprep.org
--Fax number 301-214-8602

2006-2007
MEDICAL INFORMATION FORM
GEORGETOWN PREPARATORY SCHOOL
10900 ROCKVILLE PIKE
NORTH BETHESDA, MD 20852
301-493-4500
HEALTH OFFICE: 301-214-1235 FAX: 301-214-8602

The information on this page is used by administration to assist in obtaining medical care and for contacting parents in the event of a medical emergency. This form may also accompany the student on off-campus events.

Last Name	First Name	M.I.	Date of Birth
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Address _____

Grade _____ Day Student _____ Resident _____

PERMISSION FOR EMERGENCY TREATMENT

In the event parents or legal guardians named on this form cannot be contacted, I the undersigned do hereby authorize the officials of Georgetown Preparatory School to obtain emergency medical treatment for the health of _____.

Print Student's Name

I will not hold the school responsible for the emergency care and or transportation for said student.

Signed: _____ Date: _____

EMERGENCY CONTACT PHONE NUMBERS

Physician: _____ Phone Number: _____

Mother: _____ Home Phone: _____

E-Mail: _____ Work Phone: _____

Cell Phone: _____

Father: _____ Home Phone: _____

E-Mail: _____ Work Phone: _____

Cell Phone: _____

Back Up: _____ Home Phone: _____

Contact Person Work Phone: _____

Cell Phone: _____

TO BE COMPLETED BY PARENT

INSURANCE INFORMATION

RESIDENT STUDENTS MUST SUBMIT PROOF OF HEALTH INSURANCE. WE MUST HAVE A COPY OF THE HEALTH INSURANCE CARD—FRONT AND BACK

Resident student's MUST include a copy of their health insurance card (front and back). Day students, please include a copy of the card or fill out the below information thoroughly. You must include your insurance information.

Primary Insured's Name: _____ DOB: _____
SS# _____
Health Insurance Name: _____
Type: (HMO, PPO, ETC.) _____
Policy Number: _____
Group Number: _____

BRIEF HEALTH HISTORY

TO BE COMPLETED BY THE PARENT

Please comment on any areas that may affect your son's participation in school and sports activities or would be significant information for emergency services.

Allergies to medications: _____ Type of reaction: _____

Allergies to foods, insects, etc.: _____ Type of reaction: _____

Airborne allergies: _____ Treatment: _____

Asthma: _____ Treatment: _____

Diabetes: _____ Treatment: _____

Cardiac Problems: _____ Treatment: _____

Kidney Problems: _____ Treatment: _____

Migraine Headaches: _____ Treatment: _____

Any recent or significant joint problems: _____

Any other medical concerns: _____

Any special requests: _____

2006-2007

TO BE COMPLETED AND SIGNED BY PHYSICIAN

PHYSICAL EXAM FORM

Last Name _____ First Name _____ M.I. _____

Significant Medical History:

Date Of Physical Exam: _____ Most Recent PPD Result/Date: _____
Height: _____ Weight: _____ BP: _____ P: _____

This physical was completely normal. YES NO (please explain below)

Restrictions to participation in school or sports activities: NO YES (please explain below)

Current Medications:

Additional Comments:

The above named student has my permission to receive over the counter medications: acetaminophen, pseudophedrine, ibuprofen, robitussin, pepto-bisol, loratidine, tums, antibiotic ointment, hydrocortisone cream

Physician Signature (required): _____ Date: _____

Physician Name Printed: _____

Physician Address: _____

Physician Phone: _____

CONFIDENTIALITY OF MEDICAL INFORMATION

HIPPA GUIDELINES

Georgetown Preparatory School and Health Office are being asked to comply with some new national requirements regarding confidentiality of medical information. This is known as HIPPA or Health Information Portability and Accountability Act. This act has many purposes and components, but there is one aspect that relates specifically to the students in a school situation. This component is the "privacy rule" that ensures privacy and confidentiality of all personal medical information.

Because of these new guidelines, the Prep Health Office requests your permission to discuss health issues with physicians and to submit pertinent health insurance claims related to medical problems that arise during the school year. Also, health issues that may affect a student's ability to function in the classroom may be discussed with the appropriate personnel.

I have read and understand the above information regarding HIPPA regulations and agree to allow the Prep Health Office to share and submit health information for my child as deemed necessary.

Name of Student: _____

Date: _____

Name of Parent or Guardian: _____

Signature of Parent/Guardian: _____

OVER THE COUNTER MEDICATIONS

In the course of assessment and treatment of student medical problems, it is occasionally appropriate to administer Tylenol (acetaminophen), Sudafed (pseudoephedrine), Advil (ibuprofen), Robitussin, Pepto-Bismol, Claritin, and other over the counter medications.

My son _____ may/may not receive these over the counter medications when it is deemed appropriate by the health office.

Parent/Guardian Signature: _____ Date: _____

LONG TERM PRESCRIPTION MEDICATION FORM

Long- term medication may be given, provided that the prescribing physician and parent complete the following permission request form.

Bring the medication in the original prescription bottle, properly labeled by a registered pharmacist, as prescribed by law.

NAME OF STUDENT: _____

DATE OF BIRTH: _____

To be completed by physician:

Diagnosis: _____

Name of Medication _____

Dose(s) to be given at school _____

Time(s) to be given at school _____

Other instructions _____

Side effects _____

Effective From: _____ Until: _____

Please indicate any activity restrictions _____

Signature of Physician _____ **Date:** _____

To be completed by parent:

My child has permission to receive the above medication as directed.

Parent/Guardian Signature _____ **Date:** _____

RESIDENT STUDENTS. Please indicate how you plan to have this medication refilled. _____

The school cannot accept responsibility for students taking prescription medicine during the school day without the supervision of the school nurse. For this reason, no student may possess or take prescription medicine during the school day without the supervision of the school nurse.

In an effort to ensure the safety of your son and the other students, any student found in possession of a controlled substance will be in violation of a school rule and will be subject to the consequences entailed by such an offense.

GEORGETOWN PREPARATORY SCHOOL

Athletic Consent Form

Student Name: _____ **Grade:** _____
Sport(s): _____

By signing below, I/We certify that:

PARENTAL CONSENT TO TREAT:

- A. Permission is hereby granted to the Georgetown Prep Certified Trainer, Staff, and Coaches to proceed with any necessary primary and secondary first aid. In the event of serious illness or injury I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event that I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant is given.
- B. Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer to proceed with the necessary evaluation, minor medical treatment, and/or rehabilitation for the above-named student/athlete.
- C. Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer to proceed with the necessary use of modalities (i.e. ice, moist heat, ultra sound, electric stimulation) for the care, treatment, and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the orders of the Georgetown Prep Team Physician and will only be administered by the Georgetown Prep Certified Trainer.

CONSENT TO RECEIVE MEDICATION:

Permission is hereby granted to the Georgetown Prep Certified Athletic Trainer to distribute medication (listed below) to the above-named student/athlete. Please indicate if your son should not have any of the following medications that may be available in the athletic training room for athletes.

- | | |
|--------------------------------|---------------------------------------|
| Acetaminophen (generic 200 mg) | Pepto-Bismol |
| Benadryl (25 mg) | Cepacol Throat Lozenges |
| Ibuprofen (200 mg) | Epi-Pen (0.3mg provided by physician) |
| Pseudoephedrine (generic 30mg) | Bio-Freeze (analgesic balm) |
| Bacitracin | Athletes Foot Cream/Spray Powder |
| Hydrocortisone Cream 1% | Sterile Saline Solution/Eye Powder |
| Hydrogen Peroxide | Betadine Solution |

The above-named student/athlete should not take, is allergic to, the following: _____

STATEMENT OF RISK:

I acknowledge that Georgetown Preparatory School assumes no responsibility for any risks associated with voluntary participation in school-organized athletics, physical education or other activities. Furthermore, I understand that these sports involve risk of serious injury or death. After weighing these risks against the potential benefits my son may gain from these activities, I freely and fully accept the risks of athletics on my child's behalf.

I acknowledge that Georgetown Preparatory School is not required to provide ongoing treatment for injuries that are related to non-school sports.

I also acknowledge that Georgetown Preparatory School has the right to terminate treatment if the student is non-compliant with the treatment plan that is proposed by the school trainer.

STATEMENT OF LIABILITY:

In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse, or my son against Georgetown Preparatory School and its employees arising from a sports related injury or from transportation to/from a sporting event.

INSURANCE INFORMATION:

Carrier: _____

Policy Number: _____

Physician: (Name and Telephone No.) _____

Emergency Contacts: (Name and Telephone No.) _____

SIGNED _____

DATE: _____

**MEDICAL INSURANCE DISCLAIMER
FOR FOREIGN STUDENTS**

I am aware that my son, _____, who is a student at Georgetown Preparatory School, does not have any current medical insurance beyond the basic school insurance provided by the school. I have read the attached information and understand the medical and financial limitations of the current coverage . I understand that I, and not Georgetown Preparatory School, will be responsible for payment of all medical bills that are incurred for my son, should he require medical care and treatment not covered by the school insurance policy.

I am aware of the above and still choose not to purchase additional medical insurance. I will pay all bills associated with any medical care he requires.

Signature: _____ Date: _____

I am aware of the above and will purchase additional medical insurance on my own. I will make the school aware of this information.

Signature: _____ Date: _____

You must send us a copy of the front and back of the insurance card.

MEDICAL INSURANCE INFORMATION FOR RESIDENT STUDENTS

Georgetown Prep wants to make sure you are aware of the medical insurance situation and understand what the school coverage does provide and does not provide for the students.

The Commercial Travelers School Insurance will cover any accidents or injuries that occur during school sponsored functions. If your son is injured during a sports practice or a game, the treatment will be covered. The same would hold true for any injuries that occur on campus or in the dorms.

If your son is injured off campus, at a non-school function, the insurance will NOT cover any care provided. Also, if your son were to become ill during the school year, and require care for the illness at an emergency room or hospital, the school insurance would NOT pay any of these costs.

Hopefully, none of these situations will occur during the school year. But, as you can see, the potential for an expensive medical emergency does exist. Therefore, we are asking that you purchase some form of additional medical insurance for your son. If you are unable to do this, we ask that you sign a statement indicating that you understand the current medical situation and are willing to pay out of pocket for any medical treatment your son may require.

If you are interested in getting information about additional insurance coverage for your son, the Business Office would be happy to provide you with insurance information that other Prep students have chosen to use in this situation. This insurance can be purchased on a monthly basis. Please return the attached paperwork as soon as possible. Thank you.

**FLU VACCINATION CONSENT FORM
FOR RESIDENT STUDENTS**

The Health Office will be offering the flu vaccine to all students at Georgetown Prep. This consent form must be signed before the vaccine clinic and your student must be prepared to pay at that time. We will make you aware of the date of the clinic and the cost of the vaccine after we receive our vaccine. Last year the vaccine was \$25.00. We know that the cost this year will be at least this amount. We are hoping that the clinic will be in the middle to the end of October. Please return these forms to the health clinic with your other medical forms and we will keep it on file until the time of the clinic.

I, _____ give permission for my son,
Parent Name

_____, to receive the flu vaccine from the
Student Name

Georgetown Prep Health Office during the 2006-2007 school year. I will not hold the School or associated health personnel responsible for any side effects that may accompany this immunization.

I acknowledge that my child has never had a serious reaction to a previous flu vaccine and that he is not allergic to any of the following items:

- Thimersol (a preservative found in many vaccines.)
- Gentamicin (an antibiotic)
- Eggs

Parent Signature: _____ Date: _____

- Please be aware that flu shots will NOT be given to students that are ill at the time of the clinic. If possible, arrangements will be made to do so at another time.

*****0.5 ML FLU VACCINE ADMINISTERED IN RIGHT / LEFT DELTOID*****

Aventis Pasteur Lot # _____ Exp. _____
R.N. Signature: _____ Date: _____