Showa Boston Institute Friendship Program, Summer 2017

Medical Record for American Participants

Child's Name____

Address____

Date of Birth____

Allergies to medication or other: ____

Parent/Guardian Name____

Home Address ____

Daytime Telephone________________________ Cell Phone_____________________________

Medical Insurance____

Medical Insurance ID Number____

Medical Insurance Telephone Number____

Emergency Contact if parents/guardian cannot be reached:

Name____

Relationship to child ____

Cell Telephone Number____

Medical Authorization Release;

Massachusetts law mandates that the parents of a student studying here sign a release so that he/she can receive medical treatment in case of an emergency. I hereby authorize all doctors, nurses, medical staff, administrators and teachers of Showa Boston to render routine medical treatment and emergency first aid, and to make arrangements for my child's welfare, including transportation in the event of an emergency and whatever medical care such person may, in good faith, deem necessary for my child's welfare. I hereby release from liability all such persons who, in good faith, render such routine medical treatment and emergency first aid to make such arrangements for my child's welfare pursuant to the foregoing authorization. I further authorize above-mentioned parties to release the student's pertinent medical information to parents and to Showa Boston Institute as deemed necessary, as well as the allowance of the medical personnel treating him/her to communicate reciprocally with Showa personnel and with her parents on her behalf.

Child's Name____

Parent/Guardian's Name____

Parent/Guardian Signature__________________________________ Date_______________________

Child's name ________________________________ D.O.B.: _____/_____/______M___F___

Immunization Requirements- Massachusetts requirements are listed below:

- Diphtheria, Tetanus, Pertussis (DTaP, DTP, or Tdap) (≥4 doses)
- Tdap booster (1 dose) **(between ages 11-12)**
- Measles, Mumps, Rubella (MMR or MMRV (includes Varicella) (2 doses)
- Polio (OPV or IPV) (≥3 doses)
- Hepatitis B (3 doses)
- Varicella: (2 doses)

Please attach a copy of your child's Physical Exam report, the School/ sports/ or camp health record, which must be dated within one year of the start date of this program. This must include the up-to-date list of immunizations. (We will provide blank form if required.)

Health History- Please check below if your child has had or currently has any of the health conditions listed. Please provide explanations on the blank line, and on a separate sheet if needed.

__ Recurring/chronic illness ____

__ Hospitalization/surgery in past 2 years ______________________________________

__ Recent Illness/Injury/Infection____

__ Head Injury or Concussion ____

__ Diarrhea/Constipation/Stomach Aches ____

__ Behavioral Problems ____

__ Ear Infections ____

__ Asthma/Wheezing/Shortness of Breath ______________________________________

__ Frequent/Severe Headaches ____

__ Diabetes____

__ Seizures____

__ Fainting or dizziness____

__ Chest Pain during Exercise ____

__ ADHD ____

__ Severe allergy / Anaphylaxis ____

__ Other? ____

Child's name ________________________________ D.O.B.: _____/_____/______M___F___

Consent for *self-administration* of Emergency Allergy or Asthma Medication,
This section to be completed and signed by Child's pediatrician

Please check all that apply:

__ Child will bring Allergy or Asthma emergency medicine to Showa Boston, and it may be kept in the Health Office. Child is **not** authorized to self-administer his/her Allergy/ Asthma emergency medication. Nurse is responsible.

__ Child will bring Allergy or Asthma emergency medication to Showa Boston and must keep it nearby, or on his person. And- child has been trained to administer his/her own Epi-Pen or Inhaler and is capable to do so.

Please attach separately any Individualized Allergy or Asthma Action Plans, or any other individualized instructions. Emergency measures will be instituted, per any Action Plan included, and parent / guardian or emergency contact called.

Signature of Licensed Provider __________________________________ Date____________

Printed Name________________________________ Title_______________ Phone_____________

Office Address ____

SCHOOL MEDICATION POLICY

- *Children's required medication should be scheduled at times other than during program hours, whenever possible*. Please notify Showa staff if an exception is necessary for your child and make arrangements with school nurses.
- School nurse may give OTC medications if you have checked them off, giving permission, see list.
- The school nurse is responsible for the administration of all medication. Exceptions allowed for MD approved self-administration of emergency allergy or asthma medication by child who is deemed mature and capable by MD.

Over-the-counter medication-Please check if permitting nurse to dispense and sign below:

___ Acetaminophen (Tylenol) dosage, by instructions per child's weight x 1 dose for pain or fever
___ Ibuprofen (Motrin, Advil) dosage, by instructions per child's weight x 1 dose for pain or fever
___ Benadryl 25 mg, 1 tablet x 1 dose for allergic reaction or rash
___ Bacitracin ointment as part of first aid for cuts or scrapes with bandage
___ Hydrocortisone 1% cream applied to minor itching, like mosquito bites.

Signature of Parent / Guardian ____ Date ______________

******NOTE***

Bug Spray and Sunscreen are the responsibility of the parent and child attending this program. Sunscreen, and protective clothing such as a wide brim hat or baseball cap, and sunglasses are highly recommended as your child will spend time outdoors in the full sun. We also recommend your child carry a re-usable, refillable water bottle, with carry strap or in a back pack.

Child's name ________________________________ D.O.B.: _____/_____/______M___F___

Please list *any* medications your child is *currently* taking:

Medication dose frequency/time of day condition being treated Take during program? Yes / No

____

____

____

____

Release and Liability Waiver; I, the undersigned parent or guardian, give permission to the school nurse to administer the above medication (needed during the time here at this program) to my child or to supervise my child in taking the above medication. I authorize the school nurse to share information about such medication administration as the school nurse deems necessary for the health and safety of my child. I agree to release, indemnify and hold harmless Showa Boston Institute and their employees and agents from and against any claim either I or my child may have as a result of any act or omission which may arise out of this authorization.

Emergency policy:

If any medical illness or minor injury occurs while you child is on campus, a parent / guardian or emergency contact will be called and child will be sent home at that time, with parent responsible for medical follow-up.

911 will be called first in case of any severe emergency or accident.

PARENT/GUARDIAN:

Print Name: ____ Relationship to student ___________________

Signature of Parent / Guardian ____ Date ______________

Phone numbers: Home ___________________ Work ___________________Cell _______________________