# Showa Boston Institute Friendship Program - 2018

## 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.) No student shall be admitted to the program unless they are immunized per current Massachusetts public health standards. It should also list any current medical condition(s). May be directly and securely faxed to Health Services private fax # (617)522-3471. (Please no emailed medical records due to HIPAA regulations.)

*The only exemptions allowed are for religious belief or medical reasons. Any such waivers must be signed by the child's physician, and attached to this form. Any student using this exemption may still attend all programs, even with these exemptions, except in the case where they exhibit signs of illness, or there is an outbreak, or potential exposure to a communicable childhood illness, as specified in Mass Law 105 CMR 300.200.

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**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 _____

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*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___

**NOTE: This section to be completed and signed by Child's pediatrician and the parent/guardian**

**Consent for *self-administration* of Emergency Allergy or Asthma Medication:**

**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.**

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

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

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**Signature of Licensed Provider** _____ Date_____

Printed Name_____ Title_____ Phone_____

Office Address _____

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**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 signed consent to the above release and policy:**

Print Name: _____ Relationship to student _____

Signature of Parent / Guardian _____ Date _____

Phone numbers: Home _____ Work _____Cell _____