THE ORME SCHOOL
Excellence. Tradition. Character.

Dear Orme Parents/Guardians,

We are happy to work with your student to provide the best possible healthcare while he/she is a student at The Orme School. When needed, the School's Health & Wellness Center consults with other medical specialists within the larger medical community in the greater Prescott and Verde Valley area. You can find a comprehensive description of our health philosophy, policies, procedures and medical services in The Orme School Parent-Student Handbook. Please remember that providing us with detailed, up-to-date, comprehensive health information about your student's physical and emotional health is essential to our providing ongoing care while at Orme.

Please note – All students are required to have a yearly physical examination by their primary care provider (MD, DO, or PA). The Orme School requires all students to participate in athletics; therefore, your primary care provider MUST complete the following Annual Physical Exam Form

INSTRUCTIONS:

1. Carefully read the following information. It will assist you with completing the Medical Registration Forms in this packet. If you have any concerns, or questions, please contact Ms Sherri Lyon.
2. Complete, sign and return ALL forms to:

Ms Sherri Lyon, Registrar
The Orme School
HC 63, Box 3040
Mayer, AZ 86333
slyon@ormeschool.org

Phone: (928) 632-7601
FAX: (928) 632-7605

IMPORTANT ARIZONA SCHOOL IMMUNIZATION REQUIREMENTS:
Please see the Arizona School Immunization Requirements page in this packet. It is important to take this form with you to your healthcare provider so they can review and complete any deficiency in immunizations. **Students WILL NOT be permitted to come to campus until ALL Arizona State requirements have been met, as per Arizona State Law.**

Please note – Prior to arrival on campus, a completed Arizona State Immunization Record must be sent to Ms Sherri Lyon at the above address.

Sincerely,

Bruce A. Sanborn
Head of School
The Orme School
(928) 632-7601
www.ormeschool.org

Notice of Privacy Practices

This notice describes how medical information about your child may be used and disclosed, and how you get access to this information. Please review it carefully.

This Notice of Privacy Practices is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It describes how we may use and disclose your child's protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted by law. It also describes your rights to access and control your child's protected health information. "Protected health information" is information about your child, including demographic information, that may identify him or her and that relates to his or her past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. Any such new notice will be effective for all protected health information that we maintain at that time. Upon your request, you may obtain any revised Notice of Privacy Practices by calling us and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next visit.

USES AND DISCLOSURES OR PROTECTED HEALTH INFORMATIONS

Your child's protected health information may be used and disclosed, pursuant to 45 CFR 164.502, by the Health Center, his or her treating physician at the Health Center, our staff and others outside the Health Center that are involved in your child's care and treatment for the purpose of providing health care services to him or her. Your child's protected health information may also be used and disclosed to pay health care bills and to support the operation of the Health Center.

Set forth below are examples of the types of uses and disclosures of your child's protected health care information that the Health Center is permitted to make. These examples are not meant to be exhaustive, but rather to describe for you the types of uses and disclosures that may be made by the Health Center.

Treatment – We may use and disclose your child's protected health information to provide, coordinate or manage your child's health care and any related services. For example, we may disclose your child's protected health information to a physician or health care provider (e.g., a specialist or a laboratory) who, at the request of your child's physician or the Health Center, becomes involved in your child's care.

Payment - Your child's protected health information may be used, as needed, to obtain payment for your child's health care services. For example, obtaining approval for a hospital stay may require that your child's relevant protected health information be disclosed to a health plan to obtain approval for the hospital admission.

Healthcare Operations – We may use or disclose, as needed, your child's protected health information in order to support the normal business activities of the Health Center. Examples of these activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities.

The Orme School – Medical Registration

Student Emergency Information

Name of Student: _____
First Name Middle Initial Last Name

Preferred Name: _____

Date of Birth: _____ **Grade:** _____

Social Security #: _____

Please check appropriate boxes:

☐ Female ☐ Male ☐ New Student ☐ Returning Student ☐ Boarding ☐ Day ☐ International

Parent/Guardian 1

First Name: _____ Last Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

_____

Parent/Guardian 2

First Name: _____ Last Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

_____

Emergency Contact

First Name: _____ Last Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

_____

The Orme School – Medical Registration
Student Health Insurance Information

Name of Student:_____
First Name Middle Initial Last Name

Medical Insurance Information

▸▸▸ COPY OF INSURANCE CARD REQUIRED ◂◂◂

Out of State Students – Please notify your insurance company about 'away from home' coverage.

International Students – We require American insurance coverage. Please see additional information below.

Name of Health Insurance Company: _____

Subscriber's Name: _____ Subscriber ID#: _____

Subscriber's Date of Birth: _____ Group #: _____

INTERNATIONAL HEALTH INSURANCE

- The Orme School requires international students to have American-based health insurance coverage.
- We strongly recommend ISM Insurance. ISM Insurance can be purchased online at www.isminc.com, and following the prompts for enrolling.
- The "Gold Plan" is highly recommended.

DOMESTIC HEALTH INSURANCE

- The Orme School also has options for domestic student health insurance through Assurant Health, AZ Secure STM, and 1st Med STM. If interested in any of these options, contact slyon@ormeschool.org.

I accept responsibility for all charges for outside medical services rendered to my child, and agree to promptly pay all charges associated with said services to the appropriate facility owed.

_____ _____
Printed Name of Parent/Guardian *Name of Student*

_____ _____
Signature of Parent/Guardian *Date*

The Orme School – Medical Registration

Permission for Medical Care & Release of Information Authorization

Name of Student:_____

First Name Middle Initial Last Name

I hereby give consent to The Orme School, or other instructional support staff associated with, but not limited to, The Orme School to carry out accepted procedures for diagnosis, immunization, medical and surgical treatment, or counseling for my son/daughter/ward.

In rare instances, a medical, surgical or psychiatric emergency arises in which a written consent by the parent or guardian is legally required, but the proper person cannot be located. In such circumstances, in order to avoid delay which might jeopardize the life or recovery of a student, we also request the following permission from the parents or guardians, with the understanding that effort will be made to contact them in an emergency.

I hereby grant permission to The Orme School and/or other health care providers including, but not limited to, Urgent Care (Prescott Valley), Family Medical (Dewey), Camp Verde Health Center, Verde Valley Medical Center, Yavapai County Regional Medical Center or, if on a school trip, the nearest hospital emergency room to give medical care, emergency care, necessary anesthesia and/or perform necessary surgery on my son/daughter/ward.

I hereby grant permission to The Orme School and/or necessary medical personnel to have access to my son/daughter/ward's medical records in the event of admission to a medical facility. I hereby authorize The Orme School to release medical information (including information related to drug or alcohol treatment) as required to carry out treatment, health care operations and payment, unless more specific authorization is required by law. I also authorize other health care providers who have provided medical treatment or related services to my son/daughter/ward including, but not limited to The Orme School, to release medical information (including information related to drug or alcohol treatment) to the medical facility deemed necessary to carry out treatment and health care operations, unless more specific authorization is required by law.

I authorize the release of medical information to my insurance company as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered. When parents are separated or divorced, and absent a court order to the contrary, The Orme School presumes that a non-custodial parent has access to health information and input to the same extent as a custodial parent.

My signature below indicates my consent to the above matters. This consent will remain in effect throughout my child's enrollment and attendance at The Orme School unless it is revoked by me or my son/daughter/ward's other parent or guardian.

_____ _____

Signature of Parent/Guardian *Date*

_____ _____

Signature of Student *Date*

The Orme School – Medical Registration

Medication Policy and Agreement

Name of Student:_____

First Name Middle Initial Last Name

The Orme School's Medication Policy requires that all boarding and day students notify the Health Center of all prescription and non-prescription medications being taken. The Health Center must be informed of the name, dose, amount, and prescribing physician of any medication used by a student so that interactions with other medications may be avoided and side effects recognized. Arrangements must be made with the School's medical staff for the administration of all medications to any boarding student. Prescription or non-prescription medications, including antibiotics and nutritional supplements, may not be mailed directly to students, but must be mailed or delivered directly to the Health Center. Medications given to students during school vacation breaks must be delivered to the Health Center within 24-hours of the student's arrival back on campus. The exception being any controlled substance such as Ritalin, Vyvanse, Adderall, or Focalin. These medications must be delivered by an adult or mailed to the Health Center. Misuse or abuse of any medication, including giving or selling medication to another student, is strictly forbidden. Failure to comply with this policy can be grounds for a student's dismissal. All psychotropic medications such as Ritalin, Adderall, Antidepressants, etc. must be kept under lock in the Health Center, and will be dispensed to a student as determined by their physician. Students in possession of such medications and who are not in compliance will face disciplinary action. The sharing or selling of these medications by students is dangerous and illegal, and will be treated as such. Students who abuse these medications will also face disciplinary action.

- We have provided a complete list of all medications and supplements currently taken or prescribed.
- We will update the Health Center of any changes in prescribed medications or supplements during the school year.
- Medications will be brought to the Health Center in the original container from my prescribing physician.
- Medications will be dispensed according to the schedule set by my physician.
- Medications will be taken according to the directions.
- Medications will promptly be returned to the Health Center after school vacations and breaks.
- I will not engage in misuse or abuse of my medication (i.e., hoarding medication, taking more medication than has been prescribed, snorting medication, or giving/selling medication to another student), which can result in disciplinary action by the School, including dismissal.

We agree to comply with The Orme School Medication Policy.

_____ _____

Signature of Parent/Guardian *Date*

_____ _____

Signature of Student *Date*

The Orme School – Medical Registration

Student Medical History

Name of Student:_____

First Name Middle Initial Last Name

Please answer the following questions about your student's medical history by checking the correct response. Explain all 'Yes' responses in the area provided below questions. Please respond to ALL questions.

Has student ever had, or does he/she currently have:	Yes	No	Don't Know
Restriction from sports for a health-related problem			
An injury or illness since your last physical exam			
A chronic or ongoing illness (such as diabetes or asthma)			
An inhaler or other prescription medication to control asthma			
Any prescribed or over-the-counter medications taken on regular basis			
Any allergies to medications			
Any allergies to bee stings ☐, pollens ☐, latex ☐, foods ☐ If 'Yes' to any of the above, please indicate type of reaction below ☐ Rash, ☐ Hives, ☐ Breathing difficulty or Anaphylactic reaction ☐ Other reaction – please list below			
Take any medication/EpiPen for life-threatening allergy symptoms If "Yes' please list those medications			
Ulcerative Colitis or Crohn's Disease			
Anemia, blood disorders, sickle cell disease/trait, bleeding tendencies, or blood clotting disorders			
A blood relative who died before age 50 of a heart problem			
Explain all 'Yes' answers, and include relevant dates			

Please List ALL Medications Here

Medication Name	Dosage	Frequency

The Orme School – Medical Registration

Student Medical History – page 2

Name of Student:_____

First Name Middle Initial Last Name

Has student been treated or received medication for any of the following?

	Yes	No	If 'Yes' please explain
ADD/ADHD			
Alcohol abuse			
Drug abuse			
Personality disorder			
Emotional disorder			
Depression			

History of Concussion(s) with dates:

_____

_____

My Child has Allergic Reactions to:

- Medication(s): _____
- Food(s): _____
- Insect Bite(s): _____
- Other (please specify): _____

Family Medical History, including blood relatives such as mother, father, sister, brother, grandparents.

	Yes	No	Relationship
Tuberculosis			
Hepatitis			
Gastrointestinal Disease			
Asthma			
Heart Disease			
Hypertension			
Elevated Cholesterol			
Marfan Syndrome			
Bleeding Disorder			
Kidney Disease			
Diabetes			
Rheumatologic Condition			
Epilepsy			
Cancer			
Psychiatric Illness			
Died with no known cause			
Please explain all 'Yes' answers, including relevant dates			

The Orme School – Medical Registration

Student Medical History – page 3

Name of Student:_____

First Name Middle Initial Last Name

Has student ever had, or does he/she currently have any of the following head-related conditions:	Yes	No	Don't Know
Concussion or head injury, including 'bell run' or a 'ding'			
Memory loss			
Knocked out, or loss of consciousness			
Seizure			
Migraine headaches – frequent or severe, with or without exercise			
Fuzzy or blurry vision			
Sensitivity to light or noise			
Explain all 'Yes' answers with relevant dates below:			
Has student ever had, or does he/she currently have any of these heart-related conditions:			
Restriction from sports for a heart problem			
Chest pain or discomfort			
Heart murmur			
High blood pressure			
Elevated cholesterol level			
Heart infection			
Dizziness or passing out during or after exercise without a known cause			
Has a provider ever ordered a heart test: ☐ EKG ☐ Echocardiogram ☐ Stress Test ☐ Holter Monitor			
Racing or skipped heartbeat			
Unexplained breathing difficulty, or fatigue during exercise			
Any family member, or blood relative, under age 50 with a heart condition			
Family member died while exercising – If 'Yes,' was it during or after ☐ During ☐ After			
Explain all 'Yes' answers with relevant dates below:			
Has student ever had, or does he/she currently have any of the following eye, ear, nose, mouth, or throat conditions:			
Vision correction/protection: ☐ Contacts ☐ Eyeglasses ☐ Protective Eyewear			
Hearing correction/protection: ☐ Implants ☐ Hearing Aids			
Oral correction/protection: ☐ Braces ☐ Retainer ☐ Protective Mouth Gear			
Nasal fractures, or frequent nose bleeds			
Frequent strep throat, or other EENT problems			
Explain all 'Yes' answers with relevant dates below:			

The Orme School – Medical Registration

Student Medical History – page 4

Name of Student:_____

First Name Middle Initial Last Name

Has student ever had, or does he/she currently have any of the following neuromuscular/orthopedic conditions:	Yes	No	Don't Know
Numbness – a 'burning,' 'stinging,' or pinched nerve			
Sprain or strain			
Swelling or pain in muscles, tendons, bones, or joints			
Dislocation of joint(s)			
Upper or lower back pain			
Fracture(s), stress fracture(s), or broken bone(s)			
Does student wear any protective braces or equipment			
Explain all 'Yes' answers with relevant dates below:			
Has student ever had, or does he/she currently have any general or exercise-related conditions:			
Difficulty breathing during exercise, or after running one mile			
Coughing, wheezing or shortness of breath in weather changes			
Exercise-induced asthma			
Asthma medication			
Exercise-induced dizziness, fainting or passing out			
Heat-related problems – dehydration, dizziness, fatigue, headaches			
Becomes tired more quickly than others			
Has or has had Infections: ☐ Mono ☐ Coxsacki Virus ☐ Hepatitis ☐ Lyme Disease			
Has or has had skin conditions: ☐ Impetigo ☐ Cold sores/Herpes ☐ MRSA ☐ Sun Sensitivity ☐ Warts ☐ Ringworm			
Weight gain or loss of 10 pounds or more			
Does student want to weigh more or less than they do currently			
Muscle cramps from heat ☐ Heat Stroke (red, dry skin) ☐ Heat Exhaustion (cool, clammy, damp skin)			
Absence or loss of an organ (kidney, eye, spleen, testicle, ovary, etc.)			
Explain all 'Yes' answers with relevant dates below:			

The Orme School – Medical Registration

Student Medical History – page 5

Name of Student:_____

First Name Middle Initial Last Name

Has student ever had, or been diagnosed or treated for any of the following:	Yes	No	Don't Know
Depression or Bipolar Disorder			
Anxiety, Panic Disorder or OCD			
Sleep Disorder or Insomnia			
Anorexia or Bulimia			
Attention Deficit Disorder			
Learning disability or weakness			
Psycho-educational/neurological evaluation (*please attach report*)			
Attended or advised to have counseling (*please attach report*)			
Explain all 'Yes' answers with relevant dates below:			
Has student ever had, or been diagnosed or treated for any of the following:			
Kidney Failure ☐ Received Dialysis			
Passed kidney stone(s)			
Passed blood in urine			
Females only: Age of onset of menstruation _____ How many menstrual periods in last 12 months _____ How many missed periods in the last 12 months _____			
History of painful or heavy menses			
History of urinary tract or bladder infections			
Explain all 'Yes' answers with relevant dates below:			
Males only:			
Swelling or pain in testicles or groin			
Hernia			
Explain all 'Yes' answers with relevant dates below:			

Please list any special health concerns:

_____

_____

_____

_____

_____

The Orme School – Medical Registration

Sports and Activities Permission

Name of Student:_____

First Name Middle Initial Last Name

This document contains your consent to allow your student to participate in activities with The Orme School, and your complete release of The Orme School, including its officers, directors, managers, teachers, agents and employees, from any and all related liability. Please read the below information carefully.

The undersigned is the parent or legal guardian for _____ ("Student").

I give my permission for the Student to participate in organized interscholastic athletics, horsemanship, rodeo, outdoor education training, chore programs, sustainability, disciplinary work hours, mountain biking, river rafting, rock climbing and rappelling, Caravan (week-long outdoor adventure, camping and educational trip), field trips or distance learning (with car, van, mini-bus or bus transportation), community volunteer work and other school activities (including transportation to and from any activities), realizing that such activities are possibly dangerous and involve the potential for injury. I know that, on rare occasions, the injuries can be so severe as to result in total disability, paralysis, quadriplegia, or even death. In addition, I give permission for the medical staff and/or athletic trainer to discuss my son or daughter's injuries with their coach.

In consideration of The Orme School's offering these educational experiences, I do, on behalf of myself and my Student, hereby completely release and forever discharge The Orme School (including its officers, directors, managers, teachers, agents and employees) from any and all claims, damages, liabilities or causes of action of any kind which we have or may have in the future arising out of, or relating in any way to, the participation of the Student in any of these or other types of activities with The Orme School. I also agree, on behalf of myself and the Student, to assume any and all risks associated with the Student's participation in any of these or other types of activities with The Orme School, and agree to defend and indemnify The Orme School (including its officers, directors, managers, teachers, agents and employees) against any such claims, damages, liabilities or causes of action of any kind arising out of or relating in any way to the Student's participation in any of these or other types of activities with The Orme School.

I acknowledge that I have read and understand this statement and agree to be bound by its terms. I also agree to reimburse The Orme School for any costs or expenses incurred for the Student's participation in any school activities.

_____ _____

Signature of Parent/Guardian **Date**

_____

Printed Name of Parent/Guardian

The Orme School – Medical Registration

Mandatory Physical Examination

(To be completed by examining physician)

Name of Student: _____
First Name Middle Initial Last Name

Date of Birth: _____ **Age:** _____ **Grade:** _____

Height: _____ **Weight:** _____ **B/P:** _____

Vision: **Right** _____ **Left** _____ **Both** _____ **Corrected with:** ☐ Glasses ☐ Contacts

Medical	Normal	Abnormal Findings
Appearance		
Ears/Nose/Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Metabolic/Endocrine		
Neurological		
Other		
Musculoskeletal	**Normal**	**Abnormal Findings**
Head		
Neck		
Back/Spine		
Shoulders/Spine		
Elbows/Forearms		
Wrists/Hands		
Hips/Thighs		
Legs/Ankles		
Feet		
Labs only if requested by doctor	**Normal**	**Abnormal Findings**
UA Dip		
CBC		
Chem Profile		
Other		

Athletic and Activity Participation Clearance:

- ☐ Cleared to participate in school activities
- ☐ Cleared after completed evaluation/rehab for: _____
- ☐ NOT CLEARED FOR: _____
  REASON: _____

Date of examination: _____ **Physician's Phone #:** _____

Address of Physician: _____

_____ _____
Printed Name of Physician **Signature of Physician**

Return Examination Form to: The Orme School, ATTN: Sherri Lyon, HC 63 Box 3040, Mayer, AZ 86333
FAX: (928) 632-7605 or email slyon@ormeschool.org.

Arizona School Immunization Requirements
Kindergarten - 12th Grade

- Students must have proof of all required immunizations, or a valid exemption, in order to attend school. Arizona law allows exemptions for medical reasons, lab evidence of immunity, and personal beliefs. Exemption forms are available from schools and at http://azdhs.gov/phs/immunization/school-childcare/requirements.htm. Homeless students are allowed a 5-day grace period to submit proof of immunization records.
- The immunization record for each vaccine dose must include the *complete* date and the doctor or clinicname.
- The statutes and rules governing school immunization requirements are:
  - Arizona Revised Statutes §15-871-874; and Arizona Administrative Code, R9-6-701–708

Please check requirements for each child's age and grade level in the chart below.

AGE ►	**Under 7**	**7 – 10 years**	**11 years and older**
GRADE ► ***VACCINE ▼***	**Kindergarten and above**	**Kindergarten – 5th grade**	**6th – 12 grades**
DTaP (Proof of DTP or DT counts toward DTaP requirement)	**4-5* doses** **At least 1 dose at 4 years of age or older is required.** ***A 6th dose is required if 5 doses have been given before 4 years of age.**	**3 DTaP and/or Td doses are required if all doses were given after 12 months of age.** **Or** **4 DTaP and/or Td doses are required if any of the doses were received before 12 months of age.** **Tdap** may be counted to meet the requirements above. **Tdap** is not required for 11 year olds until they enter 6th grade.	**1 Tdap dose is required for students 11 years and older.** **Students who completed the primary series of tetanus/diphtheria doses must receive a Tdap when 5 years have passed since the student's last tetanus/diphtheria dose.** **Students who did not complete the primary series of tetanus/diphtheria doses before age 11 are required to receive a total of 3 doses, including 1 Tdap and 2 Td doses.** **Tdap** doses given prior to age 11 meet the requirement. A **Td** booster is required 10 years after the **Tdap** dose.
Td			
Tdap			
Meningococcal		**Not required but may be counted as valid when given at this age.**	**1 dose is required.**
Polio	**3-4 doses** **4 doses meet the requirement. 3 doses meet requirements if dose #3 was given at 4+ years of age.** (Not required for students 18+ years of age.)		
MMR	**2 doses** **A 3rd dose will be required if dose #1 was given before more than 4 days before the 1st birthday.**		
Hepatitis B	**3 doses** **A 4th dose will be required if the third dose was given before 24 weeks of age.**		
Varicella	**1 dose is required if the first dose was given before 13 years of age.** **2 doses are required if the first dose was given at 13 years of age or later.** Students attending school or preschool in Arizona prior to 9/1/2011 with parental recall of chicken pox disease are allowed to continue attendance with parental recall of disease. Students enrolling for the first time after 09/01/2011 are required to present proof of varicella immunization or a valid exemption for medical reasons, laboratory evidence of immunity or personal beliefs.		

Note: ADHS observes a 4-day grace period for vaccine ages and intervals, except for the space between two live vaccines such as Varicella and MMR, which must be given at least 28 days apart if they are not administered on the sameday.