The Knox School

541 Long Beach Rd., St. James, NY 11780
Tel 631.686.1600 Fax 631.686.1670

HEALTH HISTORY QUESTIONNAIRE (REQUIRED)		
Student Name:	☐ M ☐ F	**Date of Birth:**
Preferred Name:		**Grade:**
Address:		
City, State:		
Zip or Postal Code:	**Country:**	
Student cell phone:		

HEALTH EMERGENCY CONTACT – PARENT/GUARDIAN/FAMILY

1) Name:	
Address:	
City, State:	
Zip or Postal Code:	**Country:**
Phone:	
Email:	
2) Name:	
Address:	
City, State:	
Zip or Postal Code:	**Country:**
Phone:	
Email:	

List any allergies (food, medication, environmental)

List any surgeries or hospitalizations:		
Year	Reason	Hospital

List any medications (prescriptions, over-the-counter, vitamins, supplements)		
Name	Dose and Frequency	Reason

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GENERAL HEALTH – HAVE YOU HAD, OR DO YOU CURRENTLY HAVE THE FOLLOWING:		
Asthma or breathing difficulties	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy or seizure disorder	☐ Yes	☐ No
Neurological concerns	☐ Yes	☐ No
Migraines or frequent headaches	☐ Yes	☐ No
Concussion or head injury	☐ Yes	☐ No
Heart condition	☐ Yes	☐ No
Stomach or gastrointestinal problems	☐ Yes	☐ No
Kidney or urinary problems	☐ Yes	☐ No
Menstruation problems	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Recent or chronic infections	☐ Yes	☐ No
Frequent sore throats	☐ Yes	☐ No
Frequent nose bleeds	☐ Yes	☐ No
Scoliosis	☐ Yes	☐ No
Hearing issues	☐ Yes	☐ No
Wear eye glasses or contacts	☐ Yes	☐ No
Premature birth	☐ Yes	☐ No
Major injuries	☐ Yes	☐ No
Muscle or skeletal injuries or issues	☐ Yes	☐ No
History of smoking	☐ Yes	☐ No
History of drug or alcohol use	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Sickle cell anemia	☐ Yes	☐ No
Any other health conditions or concerns? Explain:	☐ Yes	☐ No

MENTAL/BEHAVIORAL HEALTH - HAVE YOU HAD, OR DO YOU CURRENTLY HAVE THE FOLLOWING:		
Psychiatric or mental health concerns such as depression or anxiety	☐ Yes	☐ No
Emotional or behavioral difficulties	☐ Yes	☐ No
Recent mental or emotional stress	☐ Yes	☐ No
Have you ever been prescribed medications for a psychiatric, emotional or behavioral disorder?	☐ Yes	☐ No
Are you currently receiving mental health counseling or have you received mental health counseling in the past 12 months?	☐ Yes	☐ No
Learning disability	☐ Yes	☐ No
Special learning needs or accommodations	☐ Yes	☐ No

Parent/Guardian Signature:	**Date:**

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PERMISSION TO TREAT AND RELEASE OF INFORMATION (REQUIRED)

Student Name:	**Date of Birth:**

Understanding that my child may need emergency treatment while he/she attends The Knox School, I hereby authorize The Knox School, it's health care professionals or any other designated and/or qualified personnel, to administer first aid or other minor medical treatment as shall be deemed best under the circumstances, and I consent for my child to receive such treatment.

I further authorize The Knox School and its aforementioned staff and affiliates to carry out routine accepted procedures for diagnosis, medical or minor surgical treatment, or counseling of my child.

I understand that The Knox School will attempt to notify me in the event of an emergency requiring immediate medical care for my child and if The Knox School is unable to notify me, it will have my child treated by a duly qualified physician at the nearest hospital or emergency center. Any medical information provided to The Knox School, including this form, may be shared with emergency medical personnel.

I hereby grant permission for the physician/hospital to release information needed to process an insurance claim on behalf of my child. I also authorize The Knox School personnel to dispense medication from the school infirmary.

I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes, in writing, as they occur, e.g. telephone numbers, work location, emergency contacts, child's physician and health status, including allergies and immunization records.

Parent/Guardian Name:	
Parent/Guardian Signature:	**Date:**

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AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (REQUIRED)

Student Name:	**Date of Birth:**

I hereby authorize my child's physician/healthcare providers and The Knox School to exchange health and education information/records for the following purposes: medical diagnoses, medications, immunizations, physical exams, medical services rendered including dates and costs, provider names and contact information.

This information will be used for the following purpose(s):

1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment

I understand that I have the following rights with respect to this authorization: I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to The Knox School. My refusal will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance to this authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

I understand that my child's treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I also understand that information used or disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization is valid for one calendar year.

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Parent/Guardian Signature:	**Date:**

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NEW YORK STATE REQUIRED VACCINATION CONSENT (REQUIRED)

Student Name:	**Date of Birth:**

New York State Law Section 2164 requires that students receive certain vaccinations to enter and attend school. The Knox School understands that some students may not be able to obtain all or some of the required vaccines due to availability issues in other countries outside the United States. The Knox School Physician/Medical Director will provide those required vaccines on behalf of any student unable to meet the New York State requirements.

I have read the individual vaccine information statements prepared by the CDC or have had explained to me the information regarding the required vaccines. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the required New York State vaccinations and hereby give my consent for the above referenced student to receive any of the required vaccines they may need to maintain compliance with the above mentioned New York State Law.

I further understand that I may be held responsible for charges that are not covered by my or my child's medical insurance. If my child's medical insurance does not cover the cost of the vaccines, I understand the cost will be deducted from my child's PI account.

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OVER-THE-COUNTER MEDICATION CONSENT (REQUIRED)

Student Name:	**Date of Birth:**

Over the counter medications may be administered to your child by The Knox School's Health & Wellness staff of licensed registered nurses for conditions prescribed by our consulting doctor/medical director.

By signing this form, you are giving The Knox School permission to administer the medications listed below as needed and agree that all known allergies for your child are listed on their health history questionnaire and health examination form. You are also acknowledging that you will not hold The Knox School or its staff responsible for any claims arising out of the implementation of The Knox School's treatment procedures for your child.

Medications for Pain or Fever (generics may be used): Advil, Motrin, Aleve, Tylenol, Excedrin Migraine/Headache, Midol, Chloraseptic Throat Spray

Medications for Colds and Allergies (generics may be used): Allegra, Claritin, Zyrtec, Visine Eye Drops, Benadryl, Tylenol Cold/Flu, Tylenol Sinus, DayQuil/NyQuil, Dimetapp, Mucinex, Sudafed, Robitussin, Throat Lozenges or Cough Drops

Medications for Stomach or Gastrointestinal Discomfort (generics may be used): Mylanta, Maalox, Tums, Zantac, Imodium, Milk of Magnesia, Colace, Pepto-Bismol

Medications for Skin and Muscles (generics may be used): Hydrocortisone Cream, Caladryl, Technu, Burn Spray, Bacitracin Ointment, Triple Antibiotic Cream, Oragel, Max Freeze, Bio Freeze, Betadine, Hydrogen Peroxide, Isosopryl Alcohol, Epsom Salt

Please note, students are not permitted to keep any medications, prescription or over-the-counter in their dorm rooms. All medications must be kept in The Knox School's Health & Wellness Center including vitamins and supplements.

Parent/Guardian Name:	
Parent/Guardian Signature:	**Date:**

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SPORTS PARTICIPATION & ATHLETIC CONSENT (REQUIRED)

Student Name:	**Date of Birth:**

I hereby give my consent for the above referenced student to participate in interscholastic athletic activities and /or sports as a participant or student of The Knox School.

I am aware that with participation in sports comes the risk of injury, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the highest risk. I am aware that participating in sports involves travel with the team. I acknowledge and accept the risks inherent in the sport(s) or athletics in which my child will be participating and in all travel involved. I acknowledge having received and reviewed the below Concussion Information and have discussed the material with my child.

Furthermore, I give authorization to the Athletic Director, Athletic Trainer, Coaches, Nursing Staff and any other school official to provide any emergency and/or follow-up medical care that may become reasonably necessary for my child in the course of such athletic practice, competition or travel.

In exchange for the opportunity to participate in any athletic activities, I freely and fully waive the right of any claim against The Knox School and further agree not to hold The Knox School or anyone acting on its behalf responsible for any injury incurred to the above named student in the course of such athletic event or travel.

Concussion Information for Parents/Guardians

WHAT IS A CONCUSSION? A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION? If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE: • Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light • Sensitivity to noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY PARENTS/ GUARDIANS: • Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes

DANGER SIGNS: Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has: • One pupil (the black part in the middle of the eye) larger than the other • Drowsiness or cannot be awakened • A headache that gets worse and does not go away • Weakness, numbness, or decreased coordination • Repeated vomiting or nausea • Slurred speech • Convulsions or seizures • Difficulty recognizing people or places • Increasing confusion, restlessness, or agitation • Unusual behavior • Loss of consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. SEEK MEDICAL ATTENTION RIGHT AWAY A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

2. KEEP YOUR CHILD OUT OF PLAY. Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon - while the brain is still healing - risk a greater chance of having a second concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

3. TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION. Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

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HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY? • Ensure that they follow their coach's rules for safety and the rules of the sport. • Encourage them to practice good sportsmanship at all times. • Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained. • Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture. • However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

HOW CAN I HELP MY CHILD RETURN TO SCHOOL SAFELY AFTER A CONCUSSION? Children and teens who return to school after a concussion may need to: • Take rest breaks as needed • Spend fewer hours at school • Be given more time to take tests or complete assignments • Receive help with schoolwork • Reduce time spent reading, writing, or on the computer Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. As your child's symptoms decrease, the extra help or support can be removed gradually.

TO LEARN MORE GO TO: WWW.CDC.GOV/CONCUSSION Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

Parent/Guardian Name:	
Parent/Guardian Signature:	**Date:**

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INFLUENZA VACCINE CONSENT (OPTIONAL)

Student Name:	**Date of Birth:**

I have read the Influenza Vaccine Information Statement prepared by the CDC or have had explained to me the information regarding influenza and the influenza (flu) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I understand that I may be held responsible for charges that are not covered by my medical insurance. If my or my child's medical insurance does not cover the cost of the vaccine, I understand the cost will be deducted from my child's PI account.

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MENINGITIS B VACCINE CONSENT (OPTIONAL)

Student Name:	**Date of Birth:**

I have read the Meningitis B Vaccine Information Statement prepared by the CDC or have had explained to me the information regarding Meningitis B and the Meningitis B vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I understand that I may be held responsible for charges that are not covered by my medical insurance. If my child's medical insurance does not cover the cost of the vaccine, I understand the cost will be deducted from my child's PI account.

Parent/Guardian Name:	
Parent/Guardian Signature:	**Date:**

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HPV VACCINE CONSENT (OPTIONAL)

Student Name:	Date of Birth:

I have read the Human Papillomavirus (HPV) Vaccine Information Statement prepared by the CDC or have had explained to me the information regarding Human Papillomavirus (HPV) and Human Papillomavirus vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the HPV vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I understand that I may be held responsible for charges that are not covered by my medical insurance. If my child's medical insurance does not cover the cost of the vaccine, I understand the cost will be deducted from my child's PI account.

Parent/Guardian Name:	
Parent/Guardian Signature:	Date: