Dear Parents:

We know that getting ready for a new school year can be both exciting and hectic. Below is an explanation of Health Care forms required by the School Clinic before the start of school. Hopefully, this letter will help you get a “jump start.”

All students for the 2017-2018 school year are required to have:

- **Family Emergency Information Form** on file in the clinic prior to the first day of school. A new form is required every new school year.

- **Authorization for Medication/Treatment Form** which must be signed by a Physician or Health Practitioner licensed to practice in the State of Florida in order to dispense any medication to your child, including over the counter medication. A new form is required every new school year.

All new students, Early Childhood, Pre-K and Kindergarten students must submit the following additional health documents:

- **Copy of Birth Certificate OR copy of Passport (New Students Only)**

- **Current Physical Examination Form** (DH3040):
  This form is supplied by your physician or health care provider. The physical exam must be dated within 12 months of the first day of school. A parent must complete and sign Part One of this form. Photocopies are acceptable.

- **Florida Certificate of Immunizations Form** (DH680):
  This form is provided by your physician with documentation for the following immunizations:

  **Immunizations Required for Early Childhood/Preschool**
  - Diphtheria-Tetanus-Pertussis Series
  - Haemophilus influenzae type b (Hib)
  - Hepatitis B Series
  - Measles-Mumps-Rubella (MMR)
  - Polio Series
  - Varicella
  - Pneumococcal Conjugate(EC only)
**Immunizations Required for Kindergarten – 8th Grade**

- Diphtheria-Tetanus-Pertussis Series
- Hepatitis B Series
- Measles-Mumps-Rubella (MMR 2x)
- Polio Series
- Varicella - 2 doses required for Kindergarten thru Grade 8

**Immunizations Required for 7th Grade Entry:**

- Tetanus-Diphtheria Booster (Tdap)

These forms are required according to Florida Law! We will be unable to allow your child to attend class without these documents.

EC and PK students will also receive an **Influenza Virus Acknowledgement Form** from the teacher or nurse at Orientation. This form will also need to be completed and returned to the Clinic.

For additional help we have provided a "Clinic Checklist." If you have any questions, please do not hesitate to contact the clinic at 954-563-4508 or email us at clinic@saintmarks.com.

We hope you have a wonderful summer and that this information is helpful to you in avoiding any disappointment at the beginning of the school year.

Sincerely,

*Jami Kadivar RN and Grace Serro RN*
St. Mark’s Episcopal School
2017 - 2018 Clinic Forms Checklist

Please use this checklist as a personal reference for all required forms for the 2017 – 2018 school year.

New students (See grade level for specific documentation)

___ Family Emergency Form

___ Medication Form – Requires a doctor’s signature
   (Over the counter medication may not be administered to your child without a doctor’s signature per Florida Law)

___ Florida certificate of Immunization – DH680 (all immunizations must be documented)

___ State of Florida physical exam – DH3040 (dated on or before August 16, 2017)

___ Birth Certificate or Passport (copy accepted)

PK1-Kindergarten

___ Family Emergency Form

___ Medication Form – Requires a doctor’s signature
   (Over the counter medication may not be administered to your child without a doctor’s signature per Florida Law)

___ Current Florida Certificate of Immunization (DH680).
   *Kindergartners must have 2 doses of the Varicella vaccine before starting school and it must be documented on this form.

___ State of Florida physical exam – DH3040

1st-4th grades

___ Family Emergency Form

___ Medication Form – Requires a doctor’s signature (Over the counter medication may not be administered to your child without a doctor’s signature per Florida Law)

___ Current Florida Certificate of Immunization (DH680)

___ State of Florida physical exam – DH3040

5th-8th grades

___ Family Emergency Form

___ Medication Form – Requires a doctor’s signature (Over the counter medication cannot be administered to your child without a doctor’s signature per Florida Law)

___ Current Florida Certificate of Immunization (DH680) *7th graders must have the Tetanus booster vaccine before starting school and it must be documented on this form.

___ State of Florida physical exam – DH3040

___ FHSAA Forms; EL2, EL3
   (All students playing a team sport during the 2017-2018 school year.Forms available at https://www.fhsaa.org)
In the event a medical emergency arises during the time that a child is under the supervision of the staff of St. Mark’s Episcopal School, every attempt will be made to contact the parent/guardian of the child or other authorized person immediately. In the event that a parent/guardian or other authorized person cannot be located, the form below will serve as authorization for a member of the St. Mark’s Episcopal School staff to seek the necessary medical attention for the child.

I, ______________________________, hereby authorize a St. Mark’s Episcopal staff member to authorize medical care for ____________________________, and/or ____________________________, should the need arise, under the supervision of a physician licensed to practice medicine in the State of Florida.

Parent/Guardian Signature ________________________________ Date _________________

Three easy ways to return this form:
(1) Fax to 954-563-0504, Attention: Main School Office
(2) Deliver the form to St. Mark’s Episcopal School Main Office
(3) Mail the form to: St. Mark’s Episcopal School at 1750 East Oakland Park Boulevard, Fort Lauderdale, FL 33334
**Authorization for Medication/Treatment**

Student's Name ___________________________ Today's Date _________________________
Grade ___________ Birth Date ___________ Best Contact# ____________________________

Allergies ________________________________________________________________

Diagnosis _______________________________________________________________

Mother’s Insurance Carrier ___________________________ Social Security # ____________
Father’s Insurance Carrier ___________________________ Social Security # ____________

**Medication During School Hours and School Trips**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Check One: Yes</th>
<th>No</th>
<th>Dosage &amp; Route</th>
<th>Frequency</th>
<th>Specific Times</th>
<th>Special Instructions/Side Effects</th>
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<tbody>
<tr>
<td>TYLENOL</td>
<td>Yes</td>
<td>No</td>
<td>p.o.</td>
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<tr>
<td>Advil</td>
<td>Yes</td>
<td>No</td>
<td>p.o.</td>
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<tr>
<td>Benadryl</td>
<td>Yes</td>
<td>No</td>
<td>p.o.</td>
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<tr>
<td>Cough Syrup</td>
<td>Yes</td>
<td>No</td>
<td>p.o.</td>
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<tr>
<td>Antacid</td>
<td>Yes</td>
<td>No</td>
<td>p.o.</td>
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<tr>
<td>Anti-itch cream</td>
<td>Yes</td>
<td>No</td>
<td>topical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic ointment</td>
<td>Yes</td>
<td>No</td>
<td>topical</td>
<td></td>
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</tbody>
</table>


**Treatments During School Hours and School Trips**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Type</th>
<th>Medication Amount</th>
<th>Frequency / Specific Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaler Treatment</td>
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</tr>
<tr>
<td>Nebulizer Treatment</td>
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<tr>
<td>Blood Glucose Check</td>
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<td></td>
<td></td>
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<tr>
<td>EpiPen</td>
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<td></td>
</tr>
</tbody>
</table>

Any of the above procedures required for emergency care? Yes ____ No ____
If yes, please specify: _______________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

--- Please complete both sides of this form. ---
Authorization for Medication/Treatment
(continued)
List any limitations/precautionary measures that should be considered (e.g. physical education, outdoor activities, transporting, lifting, moving, special devices or equipment):

List any emergency precautions/health emergencies that should be anticipated for this student (e.g. allergy triggers, diabetic reactions, etc.):

Physician's Name (Print)  Physician's Signature (Mandatory)
Physician's Phone  Physician's Fax
Physician's Office Address  Date Completed:

Parental Permission for Medications/Treatment
(To be completed by the student's Parent/Guardian)
I grant the nurse, principal, or his/her designee the permission to assist or perform the administration of each medication or treatment/procedure to or for my child as instructed by my child's physician at school or during school-related events. I hereby release the School and its employees from injury, loss, or damage resulting from the school's proper administration of medications or the treatment/procedures as prescribed by my child's physician as referenced in this authorization from or in separate prescription documents.

NOTE:
- Medications must be supplied in the original container (both over-the-counter and prescription). Ask
the pharmacist to divide prescription medication into two completely labeled containers, providing
one for home and one for school.
- Only medications/treatments authorized by a physician may be administered by school personnel.
- It is your responsibility to notify the school when there is a change in medication/treatment regimen.

Parent/Guardian Name (Print)  Signature of Parent/Guardian
Date Signed:  Home Phone:
Cell Phone:  Work Phone: (include extension)
Other numbers where you may be reached during school hours:

— Please complete both sides of this form. —

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