



**PLEASE READ AND REVIEW CAREFULLY**

Midland Health Office (MHO) strives to promote every student's health and wellbeing. The Midland Student must be capable of participating in group-based community living, which means possessing age-appropriate mental, emotional, and social resilience. MHO is a dispensary and may be able to accommodate treatment plans provided by primary care physicians. MHO does not provide programs for students to resolve or treat severe behavioral, emotional, or psychological problems. MHO also cannot provide appropriate support for students attempting to quit tobacco, drug, or alcohol use, or to recover from prior substance abuse problems.

**Medical History & Information Review:** Accurate medical information supports a student's successful transition to and participation at Midland. Be Honest. MHO wants students to thrive, and we strive to accommodate most medical conditions. It is in everyone's best interest to disclose medical information upfront. MHO treats all personal medical information with some confidentiality, as certain medical information must be shared with faculty for safety and continuity of care.

One or both of the student's parents or guardians (collectively referred to as "parent/s") must complete MHO medical forms **by August 1<sup>st</sup>, 2017**. Parent/s are encouraged to complete these forms with the student. Please fill out the medical forms completely. MHO will review medical forms and contact parent/s when questions arise. In certain cases, MHO may require additional consultation with the primary care provider.

**Each student is required to have personal Health Insurance.** Please include copies of the front and back sides of all insurance cards. If your student's health insurance is not accepted, any incurred costs are charged to the student's account.

The state of **California requires immunizations for school entry**. Please see the "Midland Physical & Immunization Record Form" for specifics. Without complete and documented immunizations, your child cannot attend Midland. This includes tuberculosis testing every other year, and annually for any students living or traveling outside the United States.

While parents and students are on notice that sexual activity is prohibited at school, medical issues related to such matters present challenges for students, parents, and Midland School. Parents need to be aware that **under California law, students have a right to privacy on medical issues related to sexual matters**. Midland School encourages and highly recommends open communication on these topics between parents and students.

Family Code Section 6925 pertaining to a minor's right to privacy

- (a) *A minor may consent to medical care related to the prevention or treatment of pregnancy.*
- (b) *This section does not authorize a minor:*
  - i. *To be sterilized without the consent of the minor's parent or guardian.*
  - ii. *To receive an abortion without the consent of a parent or guardian other than as provided in Section 123450 of the Health and Safety Code. [Please note that in the case of American Academy of Pediatrics v. Lungren (1997) 16 Cal.4th 307, the California Supreme Court held that subsection (b) (2) violated an individual's constitutional right to privacy and issued an injunction against enforcement of this subsection.]*

Family Code Section 6926 pertaining to minors right to testing and treatment for sexually communicable diseases

- (a) *A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health office, or is a related sexually transmitted disease, as may be determined by the State Director of Health Services.*
- (b) *A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease.*
- (c) *The minor's parents or guardian are not liable for payment for medical care provided pursuant to this section.*

Attached is a series of additional forms. **THREE are required for ALL students** and up to FIVE additional forms if applicable.



**Midland Medical History & Information Forms**

Following THREE forms required for ALL students:

	Form to be completed by:	Required for all students
.. Midland Medical History & Information Form	Parent/ Guardian(s)	YES
.. Midland Health Insurance & Release to Treat Forms	Parent/ Guardian(s)	YES
.. Midland Physical & Immunization Record Form	Healthcare Provider	YES & Bring this form to your appointment. Important: Immunization (vaccine & TB testing) records are required

If applicable, please submit the following forms:

.. Midland ALLERGY Form	Parent/ Guardian(s)	Any allergies? If yes, then please complete this form.
.. Midland ADD/ADHD Form	Parent/ Guardian(s)	Any history with ADD/ADHD? If yes, then please complete this form.
.. Midland MEDICATIONS Form	Parent/ Guardian(s)	Any medications (Rx, OTC, herbal)? If yes, then please complete this form.
.. Midland MENTAL HEALTH Form	Parent/ Guardian(s)	Any history with mental health issues? If yes, then please complete this form.
.. Midland ORTHOPEDIC Form	Parent/ Guardian(s)	Any relevant orthopedic issues? If yes, then please complete this form.

**Submit completed forms by August 1<sup>st</sup>, 2017 to:**

**Scan & E-mail to:**

Janet Willie  
Health Director  
[office@midland-school.org](mailto:office@midland-school.org)

**USPS Mailing Address:**

Midland School  
Attn: Health Director  
P.O. Box 8  
Los Olivos, CA 93441

**Physical Address:**

Midland School  
Attn: Health Director  
5100 Figueroa Mountain Rd,  
Los Olivos, CA 93441

**Whom to contact if you have questions:**

June 6 – Aug 20, 2017: Jill Brady, Assistant to the Head of School, [jbrady@midland-school.org](mailto:jbrady@midland-school.org), 805-688-5114

August 20 – School Year: Janet Willie, Health Director, [healthdirector@midland-school.org](mailto:healthdirector@midland-school.org), 805-688-5114x136

**THANK YOU!** We are aware that careful and comprehensive completion of these forms is time consuming, and we appreciate your efforts. Please do not hesitate to contact us with any questions, concerns, or suggestions.

In Health,

Janet Willie  
Health Director



TO BE COMPLETED BY PARENT/GUARDIAN(S)

STUDENT NAME	Grade	Today's Date
Student's DOB (Date Of Birth)	Age	Gender
<u>Parent/Guardian Contact Info</u>		<u>Parent/2<sup>nd</sup> Guardian Contact Info</u>
Full Name	Full Name	
Day Phone	Day Phone	
Eve Phone	Eve Phone	
Cell Phone	Cell Phone	
E-Mail	E-Mail	

Please select "YES" or "NO" to each medically verifiable item on this list and then complete the associated details form:

<b>ALLERGIES:</b> Medications, bee/insect stings, shell fish, iodine, nuts, dairy, other foods, pollen, latex, and any other known allergies. A "NO" response means "No Known Allergies" (NKA)! <b>If "YES," then please complete the ALLERGIES Form.</b>	YES ..	NO ..
<b>ATTENTION DEFICIT (HYPERACTIVITY) DISORDER:</b> Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and other related issues. <b>If "YES," then please complete the ADD/ADHD Form.</b>	YES ..	NO ..
<b>MEDICATIONS:</b> Collectively refers to "any substance used to maintain or improve a person's health or wellbeing". Prescription, over-the-counter (OTC), supplements, herbs, homeopathic, topical, and inhalants. <b>If "YES," then please complete a MEDICATION Form for each medication.</b>	YES ..	NO ..
<b>MENTAL HEALTH ISSUES and HISTORY:</b> Anxiety disorders, panic episodes, depression, past history of suicide attempt or ideation, past addiction to alcohol or drugs, or other mental health issues. <b>If "YES," then please complete the MENTAL HEALTH Form</b>	YES ..	NO ..
<b>ORTHOPEDIC INJURIES:</b> Shoulder, arm, elbow, hand, neck, back, hips, leg, knee, ankle, foot, recurrent strains of particular muscles, recurrent sprains of particular joints, hernia, other musculoskeletal issues, and other athletic or orthopedic injuries. <b>If "YES," then please complete the ORTHOPEDIC Form</b>	YES ..	NO ..

Any "YES" answers in this column require additional information on the corresponding form.

**GENERAL HEALTH QUESTIONS:** Please read each column carefully, and respond to each item (YES, NO, or N/A – not applicable) for past or current medical issues or concerns regarding the condition/problem/illness/area listed. For items marked "Y CALL", please call the Health Office to discuss immediately.

	NO	N/A	YES		NO	N/A	YES
Addiction and/or regular use of alcohol or drugs Y CALL				Hormonal &/or Thyroid			
Asthma attack				Hypertension			
Bleeding, Blood Disorders, Tuberculosis, Hepatitis				Kidney or Liver Disease or Issues			
Cancer				Menstrual Cramps			
Cardiac (heart) Abnormalities or Problems				Neurological Disorders			
Circulatory Problems				Panic attack			
Cold Injuries				Pregnancy, current Y CALL			
Dental Problems/Issues				Reproductive Tract			
Diabetes Y CALL				Respiratory Tract			
Ear, Eye, Nose & Throat Infections/Issues/Problems				Skin Problems/Issues			
Eating Disorder (anorexia, bulimia, etc.)				Sleepwalking			
Epilepsy or Other Seizure Disorders Y CALL				Sudden death under age 50 of family member Y CALL			
Fainting or Dizziness, chronic				Syncope with exertion (fainting during exercise) Y CALL			
Gastrointestinal Tract, Ulcers				Tobacco regular use and/or addiction Y CALL			
Head Injuries, Concussions, Headaches				Urinary Tract			
Hearing Issues				Vision			
Heat Injuries/Illness				Other (explain):			

For each "YES" item from the right-hand columns above, please fully explain the history, current status, and note the treating physician's name and #'s:

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Please attach additional sheets as necessary



TO BE COMPLETED BY PARENT/GUARDIAN(S)

STUDENT NAME \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

**Participation in Activities at Midland School:** All students can expect to be challenged vigorously in mental, physical, and social activities. Please review the list below, and carefully consider if the student has the ability to participate fully. You should be aware that "average" students in "average" physical and mental condition have consistently been able to complete these activities without limitations. Typical and common activities include but are not limited to: college preparatory academics & homework; work & chores: manual labor (splitting wood); sports and athletics; hiking and camping; participating in activities that require careful attention to detail for extended periods of time; and following guidelines and rules independent of direct supervision.

Considering the above, does the student have any condition/s (e.g. mental, physical, and/or emotional) that might affect their wellbeing, the well-being of others, or the student's ability to engage in Midland activities? \_\_\_\_\_

\_\_\_\_\_

*Please attach additional sheets as necessary*

Considering the above, are there **any limitations** on the student's ability to participate in Midland activities? \_\_\_\_\_

\_\_\_\_\_

*Please attach additional sheets as necessary*

How well does this student manage their personal health (cleaning room, personal hygiene, notifying an adult when ill or injured, etc.)? \_\_\_\_\_

\_\_\_\_\_

*Please attach additional sheets as necessary*

What behavior of the student indicates they are running into trouble or struggling? \_\_\_\_\_

\_\_\_\_\_

*Please attach additional sheets as necessary*

The Centers for Disease Control and the Midland School strongly recommend all students receive the annual influenza vaccine ("flu shot"), typically in the fall. As a matter of good community health, we administer flu shots to all students annually (barring any contraindications) and charge the cost to each student's account. If you would like to opt your child out of this vaccination, please check the box to the right.  **NO Influenza Vaccine for my child**

**ACKNOWLEDGMENT/AGREEMENT:** To the best of my knowledge, this medical form contains accurate information. I understand the nature of Midland activities and acknowledge that I can contact Midland School should I have any questions about these activities or the physical or emotional demands of these activities. Other than any limitations described in this form, the student agrees, and has permission from his or her parent/s if they are a minor, to participate in all Midland activities. I agree to contact Midland if any medical or health condition(s) changes before or during the school year. I understand that providing inaccurate, or failing to provide, health and medical information can create serious risks to the student or others, and/or can result in the student's dismissal from the school. I understand that although Midland will review this information and may allow participation, Midland cannot anticipate or eliminate the risks or complications posed by a student's mental, physical, or emotional condition. I understand that emergency, medical, drug, and/or health issues; response; assessment; or treatment are included within the scope of – and expressly subject to the terms of – the Midland student contract and release forms.

Student Name PRINTED	Student Name SIGNATURE	DATE
Parent/Guardian Name PRINTED	Parent/Guardian SIGNATURE	DATE
2 <sup>nd</sup> Parent/Guardian Name PRINTED	2 <sup>nd</sup> Parent/Guardian SIGNATURE	DATE



TO BE COMPLETED BY PARENT/GUARDIAN(S)

### Health Insurance Information

STUDENT NAME	Grade	DOB	Today's Date
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#### SUBSCRIBER NAME & INFORMATION

Subscriber Name	Subscribers Date of Birth	Subscriber Last 4 Digits Social Security Number
Relationship to Insured/Student		
Employer Name	Employer Phone #	
Employer Address w/ City, State, Zip		

#### PRIMARY INSURANCE - Please attach a photocopy of both front and back of all card(s)

Insurance Company Name	Insurance Plan Name	Coverage Type
Subscriber I.D. #	Group # or name	Effective Date
RxBIN	RxPCN	Other:

#### SECONDARY INSURANCE - Please attach a photocopy of both front and back of all card(s)

Insurance Company Name	Insurance Plan Name	Coverage Type
Subscriber I.D. #	Group # or name	Effective Date
RxBIN	RxPCN	Other:

**IMPORTANT – Please attach photocopies of front and back of all health insurance cards**

### Authorization of Consent to Treatment of a Minor

I hereby declare that the care of said minor has been entrusted to the faculty and members of the administrative staff of Midland School, and that any adult member thereof is hereby authorized to act as agent for the undersigned to consent to any consultation, X-ray examination, anesthetic, dental, medical, psychological, and/or surgical diagnosis or treatment and hospital care that is deemed advisable by and is to be rendered under the general or special supervision of any dentist, physician, or surgeon licensed under the provisions of the Medical Practice Act, whether such consultation, diagnosis, or treatment is rendered on the School campus, at the office of said physician, or at a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital care that the aforementioned physician in the exercise of his/her best judgment may deem advisable. The undersigned does hereby indemnify and hold harmless Midland School and all members of the faculty and administrative staff thereof from any financial responsibility for so acting and the undersigned agrees to pay the reasonable and customary charges for any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, or hospital care provided to said minor pursuant hereto.

Student Name PRINTED	Student Name SIGNATURE	DATE
Parent/Guardian Name PRINTED	Parent/Guardian SIGNATURE	DATE
2 <sup>nd</sup> Parent/Guardian Name PRINTED	2 <sup>nd</sup> Parent/Guardian SIGNATURE	DATE



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TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

Please submit this Physical Form OR a physical form provided by your primary health care provider. The student physical must be completed within 6 months of the start of the school year. Immunization records are required & please request an updated copy from your health care provider

Medical Care Provider: Success at Midland School is dependant on a student's physical, mental, and emotional resiliency. Midland does not provide programs for students to resolve or work on severe behavioral, emotional, or psychological problems. Typical activities at Midland may include: College preparatory academics & homework; Work & chores: Manual labor (splitting wood); Sports & athletics; Hiking & camping; Participating in activities that require careful attention to detail for extended periods of time; Following guidelines and rules independent of direct supervision.

STUDENT NAME Grade DOB
Examination Date Heart Rate Blood Pressure
Height Weight BMI
Date of Last Tetanus Inoculation Tetanus Inoculation must be w/in last 10 years. Update today if needed.

Known Allergies &/or Dietary Restrictions: (Please provide an Asthma Action Plan if applicable.)

Student is under the care of a physician for the following:

Recommendations and/or restrictions regarding participation in the Midland Program:

Treatment and medications to be continued at Midland for ongoing health issues and/or recent injuries/illness:

Immunization Record/Form completed or attached YES See back of this sheet for immunization requirements

Tuberculosis Test: New students and any student who has traveled outside of the United States within the past 12 months must provide a current TB test. All other students must provide a test results every two years. Please record on reverse side.

The student can, in my opinion, fully participate in the Midland program. I am not related to the student.

Printed Name Title Date
Signature X Clinic/Hospital Name
Clinic/Hospital Address, City, State, Zip
Work Phone Mobile Phone E-mail

Thank you for your time and effort in filling out this form. If you have any questions or comments please contact us at: 805-688-5114



**Immunizations Records**

**STUDENT NAME** \_\_\_\_\_ **Grade** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

Students Admitted at Ages 7-17 Years are **required to have these immunizations** for school entry. Parents **must show their child's Immunization Record(s) as proof of immunization** (vaccines and TB testing). Please provide and attach a copy of immunization records OR complete the following completely:

Vaccination Records	Date Each Dose Was Given					
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	Booster
<b>Polio (OPV or IPV):</b> Four (4) doses (3 doses OK if one was given on or after 2 <sup>nd</sup> birthday)						
<b>Diphtheria, Pertussis, and Tetanus (DTaP, DTP, DT, Tdap, or Td):</b> Five (5) doses (3 doses OK if last dose was given on or after 2 <sup>nd</sup> birthday) & LAST dose must be after 7 <sup>th</sup> birthday						
<b>Measles, Mumps, and Rubella (MMR):</b> Two (2) doses (Both given on or after 1st birthday))						
<b>HIB:</b> Required only for child care and preschool						
<b>Hepatitis B:</b> Three (3) doses						
<b>Varicella (chickenpox):</b> One (1) dose (Admission at ages 7-12 years need 1 dose; ages 13-17 years need 2 doses).						
<b>Hepatitis A (not required)</b>						

Midland School requires up-to-date **tuberculosis (TB) testing** (within the last year for student who have lived or traveled internationally within the last year and within the last two years for all students), record below:

Has the student travelled or lived outside of United States within the last 12 months?  Yes  No

Type	Date Given	Date Read	mm	indur	Impression
<input type="checkbox"/> PPD-Mantoux					<input type="checkbox"/> Positive
<input type="checkbox"/> Other (explain)					<input type="checkbox"/> Negative
<input type="checkbox"/> PPD-Mantoux					<input type="checkbox"/> Positive
<input type="checkbox"/> Other (explain)					<input type="checkbox"/> Negative
For positive skin test, Chest X-Ray required, reading data below:					
Film Date:		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Person is free from communicable TB:	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Regarding Personal Belief Exemptions**

Forms would have to be on file on or before January 1, 2016. Governor Brown signed Senate Bill (SB) 277 on June 30, 2015 which changes immunization requirements for children entering child care or school. *“Effective January 1, 2016: Parents or guardians of students in any school or child-care facility, whether public or private, will no longer be allowed to submit a personal beliefs exemption to a currently-required vaccine.”*





If applicable, to be completed by parent/guardian(s) and attached to the Medical History & Information Form

STUDENT NAME Grade DOB Today's Date

ALLERGY Related Medical History & Information Form

Allergies are best managed with thorough information. Please note all food, environmental, medicine, substances, or material allergies of minor to extreme concern. Please complete questionnaire below and return with Health Forms by Aug. 1st. If your student has asthma, please provide an Asthma Action Plan – found at http://www.lung.org/ or from a Primary Care Provider. If your student carries an Epi-Pen, please bring two auto injectors clearly labeled.

Form section 1: Allergy/Allergen, Alternative/related/other names, and various diagnostic and management questions.

Please attach additional sheets as necessary

Form section 2: Allergy/Allergen, Alternative/related/other names, and various diagnostic and management questions.

Please attach additional sheets as necessary

Thank you for completing this form, we appreciate your careful efforts. Please contact us with any questions.



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If applicable, to be completed by parent/guardian(s) and attached to the Medical History & Information Form

STUDENT NAME

Grade

DOB

Today's Date

**ADD/ADHD Related Medical History & Information Form**

On the medical form, you listed that the Midland student has been diagnosed with ADD/ADHD. To best accommodate a student's ADD/ADHD we ask a series of questions. Please complete questionnaire below and return to Midland with all Health Forms by August 1<sup>st</sup>.

Does the student have:  Attention Deficit Disorder (ADD)  Attention Deficit Hyperactivity Disorder (ADHD)  Both ADD & ADHD

When was the ADD and/or ADHD diagnosed:

What behaviors led to the diagnosis: (inattention, hyperactivity, impulsivity, aggressive behavior)

During the last two years, has the student taken any medications for ADD/ADHD?  YES  NO

Is he/she currently taking any medications for ADD/ADHD?  YES  NO (If YES, please complete the Medications Form)

Under the current treatment, how does the student's ADD/ADHD manifest itself?

Does the ADD/ADHD interfere with school or work? If so, how?

If applicable, what happens if the student misses a medication dose?

What, if any, are the prescribed accommodations for academic type school work? Homework? Testing? Please attach additional sheets as necessary.

Does the student normally take their medication during the summer months (when not in school)?

Treating Counselor/Therapist/ Physician's Name:

Treating Counselor/Therapist/ Physician's Phone:

Additional Information:

*Please attach additional sheets as necessary*

**Thank you for completing this form, we appreciate your careful efforts. Please contact us if you have any questions.**

**PARENT(s) please note all prescription medication(s), especially ADD/ADHD medications, must be mailed directly to Midland Health Director. Students, unless prescribed to 'Self-Administer/Self-Carry', may not bring in their own medication(s).**



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Midland MEDICATIONS Form

If applicable, to be completed by parent/guardian(s) and attached to the Medical History & Information Form

STUDENT NAME

Grade

DOB

Today's Date

MEDICATIONS Form

Please complete a separate form for each medication (copy form as necessary). Medication is collectively referred to "any substance a person uses to maintain or improve a person's health or wellbeing". This includes prescription, over-the-counter, supplements, herbal, homeopathic, topical and inhalants. Midland Health Office provides common over-the-counter medications for minor ailments (headaches, cramps, cold & flu, sore throat, etc.). We ask students to not bring medications unless they are to be administered on a daily or semi-regular basis. Special or preferred "as needed" medications can be accommodated. Fill out a separate form for each daily and "as needed" medication. Medications are held in, and administered through, the Health Office. Administration times are: morning/breakfast, noontime/lunch, evening/dinner, late eveing/bedtime. Administration times different than those listed can be discussed with the Health Director.

Medication Brand Name Medication Generic/Chemical Name

Reason(s) for taking this medication

Start Date using this medication End Date (if known)

Regular Dose (quantity and frequency as perscriobed)

Time of Dose(s) and Frequency: AM/Breakfast Noon/Lunch PM/Dinner Evening/Bedtime On Request Only Other:

This medication should be taken: with food with water on an empty stomach other:

Triggers (signs & symptoms) for dosing, if applicable (e.g. onset of shortness of breath)

Common Side Effects

Uncommon Side Effects

Harmful interactions (i.e. don't give with ibuprofen)

Indications or contraindications for use?

Missed dose procedure Skip dose Take immediately Double dose at next scheduled time Call physician Other:

What happens if the student misses a dose?

Are there any medication/s that the student is currently taking that they will not be taking during their time at Midland? If so, please describe, noting the reason for medication termination.

Please attach additional information to back of sheet if necessary.

Prescribing Physician's Name: Prescribing Physician's Phone:

Resupplying medications: The Midland Health Office will inform the parent/s with a 7 to 10 days window for need of resupply. Please note resupply times on a calendar back home. ALL MEDICATION must be shipped to the MIDLAND HEALTH DIRECTOR, not shipped to the student. Medications must be in the original bottle with student name and dosing instruction. No medication will be administered that does not come in its original labeled prescription container. If a care package is included in the shipping, the package will be given to the student once the medication is removed by the Health Director.



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If applicable, to be completed by parent/guardian(s) and attached to the Medical History & Information Form

STUDENT NAME

Grade

DOB

Today's Date

**MENTAL HEALTH Related Medical History & Information Form**

We ask a series of questions of any student who has a current or past mental health history. Thank you for being honest and upfront. By doing so you help us better serve your student and their success at Midland. Please complete questionnaire below and return to Midland with all Health Forms by August 1<sup>st</sup>.

Does the Midland Student have:  Depression  Anxiety  Panic Attacks  Addiction  Other (explain):

When did symptoms first occur:

When was the above diagnosed:

What were/are the symptoms and/or behaviors:

Has the student seen a counselor or therapist in the last two years?

Is the student currently seeing a counselor or therapist?

Counselor/Therapist Name:

Counselor/Therapist Phone:

Under current treatment, how does the student's mental health issue manifest itself?

Does the mental health issue interfere with school and/or social interactions? If so, how?

Has the student ever had suicidal ideations or attempted suicide?  YES  NO If, YES, when?

During the last two years, has the student taken any medications for mental health issues?  YES  NO

Is the student currently taking any medications for mental health issues?  YES  NO (If YES, please complete the medications information form)

For stress related issues and/or mental health issues exacerbated by stress

Making new friends & learning to function in a group atmosphere, can be stressful. With that in mind: What triggers stress for the student?

What can we do at MHO to help minimize stressful situation which may arise during the school year?

Has the student ever been hospitalized for psychiatric illness?  YES  NO If yes, please explain when, and for how long, and why. Be specific.

Additional Information:

*Please attach additional sheets as necessary.*

**Thank you for completing this form, we appreciate your careful efforts. If you have any questions, see the back of the first page for whom to call. Please don't hesitate to contact us with questions.**



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If applicable, to be completed by parent/guardian(s) and attached to the Medical History & Information Form

STUDENT NAME

Grade

DOB

Today's Date

**ORTHOPEDIC Related Medical History & Information Form**

On your medical form, you listed a history of orthopedic and/or athletic type injuries. We ask a series of questions of any student with current or past orthopedic history. Thorough information can help us better accommodate the student's success at Midland. Please complete questionnaire below and return to Midland with all Health Forms by August 1<sup>st</sup>.

**Injury**

**When**

How was the injury treated?

Did the student have physical therapy?  YES  NO If, YES, for how long and when:

Does the student still have pain as a result of this injury?  YES  NO

If YES, what causes the pain and for how long?

Does the student still have loss of function or disability as a result of this injury?  YES  NO

If YES, describe the disability, be specific.

Which description best describes the student's current condition:  no longer a concern  stable  improving  worsening

Since this injury, has the student played sports, carried a backpack, run or hiked for regular intervals? Be specific.

Is the student currently taking any medications for the above injury?  YES  NO (If YES, please complete the medications information form)

Do you anticipate the student being limited in his/her ability to participate in a physically or academically demanding program?  YES  NO

If "YES", for what activities, and for how long?

**If the injury occurred within the last 6 months, or is persistent, please have the treating medical professional acknowledge participation in Midland activity and sport programs will not cause further damage or harm.**

**Injury**

**When**

How was the injury treated?

Did the student have physical therapy?  YES  NO If, YES, for how long and when:

Does the student still have pain as a result of this injury?  YES  NO

If YES, what causes the pain and for how long?

Does the student still have loss of function or disability as a result of this injury?  YES  NO

If YES, describe the disability, be specific.

Which description best describes the student's current condition:  no longer a concern  stable  improving  worsening

Since this injury, has the student played sports, carried a backpack, run or hiked for regular intervals? Be specific.

Is the student currently taking any medications for the above injury?  YES  NO (If YES, please complete the medications information form)

Do you anticipate the student being limited in his/her ability to participate in a physically or academically demanding program?  YES  NO

If "YES", for what activities, and for how long?

**If the injury occurred within the last 6 months, or is persistent, please have the treating medical professional acknowledge participation in Midland activity and sport programs will not cause further damage or harm.**



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