



Midland Health Forms 2019-2020

Midland Health Office strives to promote every student's health and wellbeing

Accurate medical information supports a student's successful participation at and transition to Midland. Be Honest when filling out all medical forms. Midland Health Office (MHO) wants students to thrive. 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.

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.

One or both of the student's parents or guardians (collectively referred to as "parent/s") must complete MHO medical forms **by August 1st, 2019**. 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.

This Health Form packet must include copies of the front and back sides of all insurance cards. Please note PPO and HMO insurances are often only accepted outside of your primary care physician's office with prior authorization. If your student's health insurance is not accepted, any incurred costs are charged to the student's account. Please update MHO with changes to Health Insurance.

State of California immunizations requirements 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, or annual testing for all students living or traveling outside the United States within the year.

<https://www.shotsforschool.org/k-12/>

<https://www.cdc.gov/vaccines/parents/protecting-children/years-13-18.html>

State of California law provides rights to privacy on sexual medical issues

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 between parents and students on these topics.

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

<http://teenhealthlaw.org/wp-content/uploads/2018/11/CaliforniaMinorConsentConfChartFull11-20-18.pdf>



Midland Health Forms 2019-2020

The following Health Forms are required for **ALL** students:

- Midland Medical History & Information Form (3 pages)
- Physical & Immunization Record Form which a Healthcare Provider must complete. (2 pages)
 - a) Please provide updated and complete vaccination information.
 - b) Note: the Tdap vaccination – tetanus, diphtheria, and pertussis vaccination must be administered **after** the 7th birthdate.
 - c) TB testing is to be completed:
 - by all new incoming students.
 - annually for all students living or traveling outside of the U.S..
 - every two years for returning students who live and travel only within the U.S.

The state of California requires immunizations for school entry.

Without complete and documented immunizations, your child cannot attend Midland.

<https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>

Additional Health forms if applicable to be completed by parent or guardian

- ALLERGY Form – current or history of allergy to medicine, foods, environmental, materials, etc. Please provide personal Epi-Pen if applicable.
- ADHD Form – current or history of ADHD. Please provide testing data
- MEDICATIONS Form – medications include substance used to enhance one's well being. Prescription, herbal, homeopathic, topical
- MENTAL HEALTH Form – current or history of. Please contact Health Director if hospitalizations or out-patient profile within last 2 yrs.
- ORTHOPEDIC Form – current or relevant history

Submit completed forms by August 1st, 2019 to:

Upload Health forms:

https://www.mymidlandschool.org/public/resources/uploads/2018-19_Midland_School_Health_Forms_All_1531255265.pdf

Scan & E-mail to: Midland Health Director office@midland-school.org

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

Who to contact us if you have questions:

June 4 – Aug 15, 2019: Jill Brady, Assistant to the Head of School, jbrady@midland-school.org, 805-688-5114

August 16 – School Year: Janet Willie, Health Director, 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.



Midland Medical History & Information Forms
TO BE COMPLETED BY PARENT/GUARDIAN(S)

STUDENT NAME _____ Grade _____ Date of Birth: _____
Age: _____ Gender: _____ Preferred Pronouns: _____

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 _____ Student Name _____ DATE _____
PRINTED SIGNATURE
Parent/Guardian _____ Parent/Guardian _____ DATE _____
Name PRINTED SIGNATURE
2nd Parent/Guardian _____ 2nd Parent/Guardian _____
Name PRINTED SIGNATURE

Health Insurance Information

SUBSCRIBER NAME & INFORMATION

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

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

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

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

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

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



Midland Medical History & Information Forms
TO BE COMPLETED BY PARENT/GUARDIAN(S)

STUDENT NAME _____ **Grade** _____ **DOB** _____ **Today's Date** _____

Annual influenza vaccine

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 provide and administer flu shots to all students annually (barring any contraindications). The charge of approximately \$20 goes to each student's account. If you would like to opt your child out of this vaccination, please check the box:

NO Influenza Vaccine for my child. If influenza vaccine given elsewhere – provide the date and location:

Please select "YES" or "NO" to each medically verifiable item on this list.

Complete the associated details form if applicable:

ALLERGIES: 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)! If "YES," then please complete the ALLERGIES Form.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER: Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and other related issues. If "YES," then please complete the ADD/ADHD Form.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
MEDICATIONS: 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. If "YES," then please complete a MEDICATION Form for each medication.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
MENTAL HEALTH ISSUES and HISTORY: Anxiety disorders, panic episodes, depression, past history of suicide attempt or ideation, past addiction to alcohol or drugs, or other mental health issues. If "YES," then please complete the MENTAL HEALTH Form	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ORTHOPEDIC INJURIES: 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. If "YES," then please complete the ORTHOPEDIC Form	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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 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 <input type="checkbox"/> 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 <input type="checkbox"/> CALL			
Dental Problems/Issues				Reproductive Tract			
Diabetes <input type="checkbox"/> CALL				Respiratory Tract			
Ear, Eye, Nose & Throat				Skin Problems/Issues			
Infections/Issues/Problems				Sleepwalking			
Eating Disorder (anorexia, bulimia, etc.)				Sudden death under age 50 of family member <input type="checkbox"/> CALL			
Epilepsy or Other Seizure Disorders <input type="checkbox"/> CALL				Syncopal with exertion (fainting during exercise) <input type="checkbox"/> CALL			
Fainting or Dizziness, chronic				Tobacco regular use and/or addiction <input type="checkbox"/> CALL			
Gastrointestinal Tract, Ulcers				Urinary Tract			
Head Injuries, Concussions, Headaches				Vision			
Hearing Issues				Other (explain):			
Heat Injuries/Illness							

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:



Midland Medical History & Information Forms
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.*

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 nd Parent/Guardian Name PRINTED	2 nd Parent/Guardian SIGNATURE	DATE

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?

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

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

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



Physical & Immunization Record Form Annual Health Physical

TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

Please complete 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. Note TB and Tdap requirements. Please request an updated copy from your healthcare provider,

To the Medical Care Provider: Success at Midland School is dependent 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 and homework; Work and 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; 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.*

Date of last Tdap: last dose must be given after 7th birthday

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 page 2.

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** **Page 2 of this sheet for immunization requirements**

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**



Physical & Immunization Record Form 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. Please provide and attach a copy of immunization records and TB testing OR complete the immunization chart below:

For more information see: <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>

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

Midland School requires up-to-date **tuberculosis (TB) testing**.

TB testing is to be completed:

- by all new incoming students.
- annually for all students living or traveling outside of the U.S..
- every two years for returning students who have lived and traveled only within the U.S.

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"/> Other (explain)				<input type="checkbox"/> Positive <input type="checkbox"/> Negative
<input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other (explain)				<input type="checkbox"/> Positive <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.”*



ALLERGY 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** _____

ALLERGY Related Medical History & Information Form

Allergies are best managed with thorough information. Please note all medicine, food, environmental, 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.

Allergy/Allergen: _____

Alternative/related/other names: _____

When was student diagnosed with this allergy? _____

How was student diagnosed to this allergen? _____

Signs and Symptoms during an allergic reaction, what happens? _____

During a reaction has the student suffered any face swelling and/or difficulty breathing (anaphylactic reaction)? YES NO

Do you think your child's allergy may be life-threatening? YES NO
(If yes, contact Midland Health Director)

Has a health care provider verified this allergy may be life-threatening? YES NO

Does the student have and carry epinephrine for this allergy? YES NO
(If YES, the student must bring **two** delivery devices to Midland)

Does the student take any medication for this allergy? YES NO
(if yes - complete the medications information form)

Has the student ever been hospitalized for this particular allergy? YES NO
(If YES, explain in detail on separate sheets as necessary)

Is the student on an allergy desensitization program? YES NO
(If YES, will this require treatments while at Midland? Please explain in detail)

Additional Information: _____

Allergy/Allergen: _____

Alternative/related/other names: _____

When was student diagnosed with this allergy? _____

How was student diagnosed to this allergen? _____

Signs and Symptoms during an allergic reaction, what happens? _____

During a reaction has the student suffered any face swelling and/or difficulty breathing (anaphylactic reaction)? YES NO

Do you think your child's allergy may be life-threatening? YES NO
(If yes, contact Midland Health Director)

Has a health care provider verified this allergy may be life-threatening? YES NO

Does the student have and carry epinephrine for this allergy? YES NO
(If YES, the student must bring **two** delivery devices to Midland)

Does the student take any medication for this allergy? YES NO
(if yes - complete the medications information form)

Has the student ever been hospitalized for this particular allergy? YES NO
(If YES, explain in detail on separate sheets as necessary)

Is the student on an allergy desensitization program? YES NO
(If YES, will this require treatments while at Midland? Please explain in detail)

Additional Information: _____

Please attach additional sheets as necessary



ADHD 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** _____

ADHD Related Medical History & Information Form

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

When was the 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 ADHD? YES NO

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

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

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

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

Has the student been prescribed accommodations for academic type school work? Homework? Testing?
Please provide testing data. _____

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

Treating Counselor/Therapist/ Physician's Name: _____

Phone: _____

Office address: _____

Date of most recent appointment: _____

Length of time under physician's care: _____

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 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).



MEDICATION Form

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

STUDENT NAME

Grade

DOB

Today's Date

Resupplying medications Instructions:

- Please note resupply times on a calendar back home. The Midland Health Office will inform the parent/s with a 7 to 10 days window for need of resupply.
- **ALL MEDICATION must be shipped to the MIDLAND HEALTH DIRECTOR, not shipped to the student.**
- Medications must be in the original bottle with correct student name and current 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.

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 evening/bedtime. Administration times different than 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 prescribed)

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:

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:

Prescribing Physician's address:



MENTAL HEALTH 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

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 1st.

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:

Counselor/Therapist Address:

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?

For stress related issues and/or mental health issues exacerbated by stress, making new friends and learning to function in a group atmosphere, can be stressful. With that in mind: What triggers stress for the student?

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)

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.



ORTHOPEDIC Form

If applicable, to be completed by pa/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 1st.

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.

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.

Please attach additional sheets as necessary