MIDLAND SCHOOL
Live Your Education

Midland's Health Office strives to promote student health and well-being.

Accurate medical information supports a student's successful transition to Midland. Midland Health Office (MHO) is a key support for 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 level of confidentiality. Certain medical information must be shared with faculty for safety and continuity of care of the student involved.

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 July 15th, 2020.** Parent/s are encouraged to complete these forms with the student. 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. If you experience a delay in obtaining a school physical, please send in Packet 1 forms by July 15th and Packet 2 forms as you are able.

Midland Health Office continues to closely monitor recommended practices regarding health and safety amid COVID-19, including the relevant State and County Health Department guidelines. Midland families can expect further information (as it becomes available) regarding pre-screening and arrival screening that may be required.

PAGE	MHO FORMS	ACTION ITEM
Packet 1	**2020-2021 MIDLAND SCHOOL HEALTH FORM**	**Due July 15, 2020**
1	Authorization of Consent to Treatment a Minor & Acknowledgement/Agreement	Parent/s or guardian/s signatures
2	Insurance Information	Front & back copy of all insurance cards
3	Health Information + Additional Addendum Forms (as applicable) Addendum Forms: Allergy | ADHD | Medication | Mental Health | Orthopedic	Addendums + Additional sheets (as applicable)
4	Participation in Activities at Midland School	Parent/s or guardian/s complete form
Packet 2	**2020-21 HEALTH PHYSICAL & IMMUNIZATION FORM**	**Due July 15, 2020**
1	Annual Health Physical	Health Provider Signatures/Stamp
2	Immunization Records	Health Provider completes and signs. Attach Immunization & Annual Flu Vaccine Records
3	California Pediatric Tuberculosis Risk Assessment	Health Provider completes and signs.

PRIVACY NOTICE

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. Please review.

UPLOADING MHO FORMS

The fastest and easiest way to submit your MHO forms is through the MyMidland portal. If for some reason you are unable to access the portal for uploading your forms, you can also scan and email the forms, or mail in hard copies.

Upload the Form via MyMidland (preferred)

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

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

QUESTIONS? Contact:
June 4 – Aug 15, 2020 | Jill Brady, Assistant to the Head of School, office@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 effort. Please do not hesitate to contact us with any questions, concerns, or suggestions.

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

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

TO BE COMPLETED BY PARENT/GUARDIAN(S)

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

Insurance 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

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TO BE COMPLETED BY PARENT/GUARDIAN(S)

STUDENT NAME Grade Date of Birth:

Age: Gender: Preferred Pronouns:

Please select "YES" or "NO" to each medically verifiable item on this list. Complete the **associated form** if applicable:

ALLERGIES: Medications, bee/insect stings, shellfish, 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 for each type (medication, food, environmental,substance, material),*	YES ☐	NO ☐
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER: Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and other related issues. *If "YES," then please complete the ADHD Form.*	YES ☐	NO ☐
MEDICATIONS: Collectively refers to "any substance used to maintain or improve a person's health or wellbeing". Prescription, over-the-counter (OTC), supplements, herbal, homeopathic, topical, and inhalants. *If "YES," then please complete a MEDICATION Form for EACH medication.*	YES ☐	NO ☐
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 ☐	NO ☐
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 ☐	NO ☐

GENERAL HEALTH QUESTIONS: current or past medical issues or concerns. Please read each column carefully, and respond to each item (NO, N/A –not applicable, or YES) regarding the condition/problem/illness/area listed. For each "YES" please fully explain the history, current status, and note the treating physician's name and contact information, attaching additional sheets as needed.

	NO	N/A	YES
Addiction and/or regular use of alcohol or drugs *If YES, please CALL*			
Asthma Attack			
Bleeding, Blood Disorders, Tuberculosis, Hepatitis			
Cancer			
Cardiac (heart) Abnormalities or History			
Circulatory Problems			
Cold Injuries			
Dental Problems/Issues			
Diabetes | *If YES, please CALL*			
Ear, Eye, Nose & Throat Infections/Issues/Problems			
Eating Disorder (anorexia, bulimia, etc.) *If YES, please CALL*			
Epilepsy or Other Seizure Disorders *If YES, please CALL*			
Fainting or Dizziness, chronic			
Gastrointestinal Tract, Ulcers			
Head Injuries, Concussions, Headaches			
Hearing Issues			
Heat Injuries/Illness			

	NO	N/A	YES
Hormonal &/or Thyroid			
Hypertension			
Kidney or Liver Disease or Issues			
Menstrual Cramps			
Neurological Disorders			
Panic attack			
Pregnancy, current			
Reproductive Tract			
Respiratory Tract			
Skin Problems/Issues			
Sleepwalking			
Sudden death under age 50 of family member *If YES, please CALL*			
Syncope with exertion (fainting during exercise) If YES, please CALL			
Tobacco, vaping, marijuana regular use and/or addiction | *If YES, please CALL*			
Urinary Tract			
Vision			
Other (explain & *please CALL*):			

TO BE COMPLETED BY PARENT/GUARDIAN(S)

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

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 history of or current mental, physical and/or emotional condition/s or concerns that might affect their well-being, 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?

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TO BE COMPLETED BY PARENT/S (IF APPLICABLE)
Today's Date:

ADDENDUM | Allergy Form | Page 1 of 1
Attach to Midland School Health Forms

STUDENT NAME	Grade	DOB

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 the questionnaire below and return with Health Forms by July 15th.

- ➔ 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.

NOTE: Please complete a separate form for each allergy category: medicine, food, environmental, substances, or material.

Allergy/Allergen: **Alternative/related/other names:**

When was the student diagnosed with this allergy?

How was the student diagnosed with 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? *(If YES, contact Midland Health Director)*	☐ YES ☐ NO
Has a health care provider verified this allergy may be life-threatening?	☐ YES ☐ NO
Does the student have and carry epinephrine for this allergy? *(If YES, the student must bring **two** delivery devices to Midland)*	☐ YES ☐ NO
Does the student take any medication for this allergy? *(If YES, be sure to complete the medications information form)*	☐ YES ☐ NO
Has the student ever been hospitalized for this particular allergy? *(If YES, explain in detail on separate sheets as necessary)*	☐ YES ☐ NO
Is the student on an allergy desentization program? *(If YES, will this require treatments while at Midland? Please explain in detail)*	☐ YES ☐ NO

Additional Information:

Please attach additional sheets as necessary

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TO BE COMPLETED BY PARENT/S (IF APPLICABLE)
Today's Date:

ADDENDUM | ADHD Form | Page 1 of 1
Attach to Midland School Health Forms

STUDENT NAME	Grade	DOB

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 the questionnaire and return to Midland with all Health Forms by July 15th.

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

Are they currently taking any medications for ADHD? □ YES □ NO (If YES, please complete the Medications Form)

When did they first start taking this medication?

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

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

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

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

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

Treating Counselor/Therapist/ Physician's Name:
Phone:
Office address:
Date of most recent appointment: Length of time under physician's care:

TO BE COMPLETED BY PARENT/S (IF APPLICABLE)
Today's Date:

ADDENDUM | Medication Form | Page 1 of 1
Attach to Midland School Health Forms

STUDENT NAME	**Grade**	**DOB**

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. ALL medications are held in and administered from the Health Office. *We ask students only bring medications to be administered on a daily or semi-regular basis.* The Health Office stocks and provides common as needed over-the-counter medications. Self-administration of daily topicals and inhalants may be allowed following a check with the Health Office.
Medication administration times are: morning/breakfast, noontime/lunch, evening/dinner, late evening/bedtime, and as needed.

Resupplying Medication Instructions	**Please initial**
Note upcoming resupply times on a calendar allowing for shipping time. A reminder emailed to parent(s)/guardian(s) will be sent 7 to 10 days prior to need of a resupply.	
Medications must be in the original bottle with correct student name and current dosing instruction. Changes to medication dosing/administration needs documentation from the prescribing care practitioner.	
All medication must be shipped in care of the Midland Health Office, not shipped to the student. The Health Director is happy to remove medications from a care package and get the package to the student.	

NOTE: Please complete a separate form for each medication category.

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)
Administration Time: ☐ AM/Breakfast ☐ Noon/Lunch ☐ PM/Dinner ☐ Evening/Bedtime ☐ As Needed ☐ 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?

Please attach additional information to back of sheet if necessary.

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

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TO BE COMPLETED BY PARENT/S (IF APPLICABLE)
Today's Date:

ADDENDUM | Mental Health Form | Page 1 of 1
Attach to Midland School Health Forms

STUDENT NAME	Grade	DOB

MENTAL HEALTH Related Medical History & Information Form
Below are a series of questions for any student who has a documented mental health history. Thank you for being honest and upfront. By doing so you help us better serve and support your student's success at Midland.

Does the Midland Student have: ◻ **Depression** ◻ **Anxiety** ◻ **Panic Attacks** ◻ **Addiction** ◻ **Other:**__________

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? ◻ YES ◻ NO

Are they currently seeing a counselor or therapist? ◻ YES ◻ NO

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 situations 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. Please contact us with further questions.

TO BE COMPLETED BY PARENT/S (IF APPLICABLE)
Today's Date:

ADDENDUM | Orthopedic Form | Page 1 of 1
Attach to Midland School Health Forms

STUDENT NAME	Grade	DOB

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 the questionnaire below and return to Midland with all Health Forms by July 15th .

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?*

Please attach additional sheets as necessary

If the injury occurred within the last 6 months, or is persistent, please have the treating medical professional acknowledge in writing, or through email sent to healthdirector@midland-school.org, that participation in Midland activities and sport programs will not cause further damage or harm. Please provide an orthopedic and/or physical therapy care plan if applicable. When possible, always schedule follow-up appointments to coincide with school calendar vacation dates.