Grand River Academy
3042 College St., PO Box 222
Austinburg, OH 44010
Phone: 440-275-2811 Fax: 440-275-1825

MANDATORY HEALTH FORMS

All forms must be completed prior to enrollment

Contact Information:

School Nurse: nurse@grandriver.org

Admissions: admissions@grandriver.org

Checklist of Required Forms & Items:

1. Emergency Treatment/ Routine Care Medical Authorization Form
    a. Complete online www.schooldoc.com
2. HIPAA Waiver Authorization Form
    a. Complete online www.schooldoc.com
3. Physical Evaluation & Vaccination Form
    a. This form must be signed by the Physician.
    b. Upload online www.schooldoc.com
4. Request for the Administration of Non-Prescription Medication (OTC) Form
    a. This form must be signed by a parent or guardian and a physician. "Yes" column must be marked to administer medications.
    b. Upload online www.schooldoc.com
5. Request for the Administration of Prescription and Specific Non-Prescription Form
    a. This form must be signed by a parent or guardian and a physician.
    b. Upload online www.schooldoc.com
6. Photocopy of both sides of the Insurance Card
    a. Upload online www.schooldoc.com
7. Health Coverage (International Students)
    a. Register and Upload online www.schooldoc.com
8. PersonalRx Information Form
    a. Register and Upload online www.schooldoc.com

Please make sure all forms are completely filled out and signed before uploading to schooldoc.

Grand River Academy
Emergency/Routine Care Medical Authorization

3042 College St., PO Box 222
Austinburg, OH 44010
Phone: 440-275-2811 Fax: 440-275-1825

Student's Name: _____

Home Address: _____

City _____ State _____ Zip code _____

Home phone _____

Cell (Mother) _____ Mother's Date of Birth _____

Cell (Father) _____ Father's Date of Birth _____

3rd Party Emergency Contact: _____ Relationship _____

Home Phone: _____ Cell _____

ALLERGIES TO MEDICATIONS-- If no allergies, write NONE

_____

Consent Statement: Authorizing Treatment:

This permission is required to facilitate timely provision of medical, mental health and social care while your child is attending Grand River. Every effort will be made to contact the child's parent/guardian for serious illnesses, serious injuries, operations or protracted or complex treatments. I hereby authorize and grant members of Grand River's Health Center, Athletic Training Department, and other designated adult representatives permission to administer care and treatment for my son. Such care and treatment shall include: injuries and illness, the administration of medications, and such treatment as deemed necessary in case of an emergency. To ensure compliance with Ohio State Law regarding the school vaccination requirements, I also give permission for the administration of any vaccines (Td, Tdap, IPV, MMR, Hepatitis B, Varicella, and MCV4) if my child does not have documentation of serologic immunity or documentation proving he had already received such immunizations. I agree to pay charges for such immunizations. I also give permission to the medical department and school physician (or his designee) to hospitalize and or secure proper treatment for my son in case of a medical/surgical/dental/psychiatric emergency, provided they are unable to communicate with me and, if, according to their best professional judgment, further delay might jeopardize the welfare of my child. I also give permission to release pertinent medical information to Grand River Faculty on a need-to-know basis as well as to other physicians and therapists to whom the child is referred. I give permission to Grand River or designated personnel to represent me during the year with full power to authorize and consent to any treatment for my child in an Emergency Room, (such as at the local ACMC Hospital), or medical, rehabilitative, mental health or dental office. Furthermore, I understand any and all students may choose to check in with Grand River Counseling professionals on an as-needed basis. In addition, if Grand River Counseling professionals deem my child to be in need of any ongoing therapeutic counseling support, I will be involved in this decision. I acknowledge that my son will be completing the Prospectives Academy Social Skills Course through Grand River Academy's Student Life Curriculum.

PERMISSION TO PARTICIPATE IN SPORTS/ACTIVITIES: I hereby acknowledge awareness that participation in all sports, activities and events involves some risk of injury, which may rarely include severe injury, possibly involving paralysis, permanent mental disability or death, and that these injuries may occur in some instances as a result of unavoidable accident. I hereby accept these risks and give consent to participation by my child in all sports, activities and events while he is attending school. Forms of treatment to which you object: If none, write none. _____

_____

Custodial Parent/Guardian Signature: _____

Student's Signature (if over 18): _____

Grand River Academy

HIPAA Waiver Authorization

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), a federal privacy law protects individual identifiable health information.

HIPAA requires an authorization in order for Grand River Academy to be able to use or disclose protected health information (PHI). This authorization describes the scope and nature.

I authorize Grand River Academy to use and disclose protected health information for the purposes described below:

^*Medical history, results of physical exams, blood tests, X-rays, and other diagnostic and medical procedures*

^*To allow Grand River Academy to speak to medical personnel for reasons that may include doctor's visits, hospital visits, and medical emergencies*

Grand River Academy complies with HIPAA and its privacy requirements and all other laws that protect privacy. We will protect information according to these laws. Despite these protections, there is a possibility that information could be used or disclosed by someone else to whom it is released in a way that it will no longer be protected.

I authorize the use of identifiable health information as described in this form.

Student Name (Please Print)	Name of Parent/Guardian (Please Print)
Signature of Student 18 years of age or older.	Signature of Parent/Guardian

Grand River Academy Physical Evaluation

Student Name_____ Date of Birth_____ Grade_____

To be completed by the physician:

Height_____ Weight_____ B/P_____

Vision	Hearing	Postural
Date Performed / /	**Date Performed** / /	**Date Performed** / /
Distance Acuity _____R _____L Muscle Balance ☐ Pass ☐ Fail Stereopsis ☐ Pass ☐ Fail Color ☐ Pass ☐ Fail Student wear glasses? ☐ Yes ☐ No Tested with glasses? ☐ Yes ☐ No Referral made? ☐ Yes ☐ No	Pure Tone Right Ear ☐ Pass ☐ Fail Left Ear ☐ Pass ☐ Fail Student wears hearing aid? ☐ Yes ☐ No Referral made? ☐ Yes ☐ No	☐ No abnormality noted ☐ Screening not done ☐ Referral made Comments _____ _____

	Normal	Abnormal	Comment
Head, Eyes (PERL), Ears, Nose			
Mouth, Teeth, Pharynx			
Neck, Thyroid, Lymph Nodes			
Lung sounds			
Heart_rhythm/rate			
Abdomen			
Extremities, joints			
Spine			
Skin			

Do you have any allergies? (medicine, environmental, insects, food) _____

Any other medical concerns school should be aware of?_____

Cleared for Sports:	YES	NO
Cleared without restrictions		
Not cleared for Sports		
If not cleared, please explain:		

To be completed by the physician:

Immunizations (Ohio Law--- Shaded areas are required by law)

Please attach copy of Immunization Record

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DPT diphtheria, pertusis, tetanus					
Tdap Booster, 7th grade					
Polio					
Measles, Mumps, Rubella					
Hepatitis B					
Varicella (chicken pox)					
BCG (*international students*)					
Meningitis					

Signature of Physician_____ Date_____

Name of Physician (Print)_____ Phone_____

Signature of parent/guardian_____

Grand River Academy
Administration of Prescription
Non-prescription Medication by School Personnel

Ohio law mandates that schools have on file a signed statement by the Parent/Guardian and Physician for all non-prescription (over-the-counter) medications that are administered to students. Students are not permitted to have any prescription or non-prescription medication in their possession with the exception of Epi-pen, Inhalers and Insulin supplies.

This form is required to be signed by a physician every time there is a change and/or addition to prescription and Non-prescription medications.

Student Name_____ Date of Birth_____

Allergies to Meds_____ (if no allergies, write NONE).

I request that above named student be given the medication(s) listed below which is being supplied through PersonalRX.

Name of Prescription Med.	Dosage	Time Given	Purpose

Example of Non-prescription medications include, but not to be limited to: Fish/Krill oil, ANY vitamins, Melatonin, Acid-Reducers (Pepcid), Antihistamines (Claritin, Zyrtec), Nutritional supplements, etc...

Name of Non-Pres. Med.	Dosage	Time Given	Purpose

Signature of Physician_____ Date_____

Name of Physician (Print)_____ Phone/Fax_____

Signature of parent/guardian_____

Physician ONLY: Discontinue the following Medication:

_____

Physician Signature _____ Date_____

Grand River Academy
Administration ofPrescription
Non-prescription Medication by School Personnel

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Name of Prescription Med.	Dosage	Time Given	Purpose

Example of Non-prescription medications include, but not to be limited to: Fish/Krill oil, ANY vitamins, melatonin, acid-reducers (Pepcid), anti-histamines(Claritin, Zyrtec), nutritional supplements, etc...

Name of Non-Pres. Med.	Dosage	Time Given	Purpose

Signature of Physician_____ Date_____

Name of Physician (Print)_____ Phone/Fax_____

Signature of parent/guardian_____

Physician ONLY: Discontinue the following Medication:

_____

Physician Signature _____ Date_____

Grand River Academy

Request for Administration of

Non-prescription Medication (OTC) by School Personnel

STUDENT NAME_____ Date of Birth_____

ALLERGIES to MEDICATIONS_____ (if no allergies, write NONE).

Ohio law mandates that schools have on file a signed statement by the Parent/Guardian and Physician for all non-prescription (over-the-counter) medications that are administered to students.

Students are not permitted to have any prescription or non-prescription medication in their possession with the exception of Epi-pen, Inhalers and Insulin supplies.

This form is required to be signed by a physician every time there is a change and/or addition to prescription and Non-prescription medications.

Non-prescription medications listed below are available at the school. Please mark "YES" or "NO" for each Medication listed to dispense as deemed necessary for minor illness/injury at the discretion of the School Nurse and/or school personnel.

YES	NO	MEDICATION	
		Acetaminophen (Tylenol)	relieve pain, reduce fever/discomfort
		Airborne Gummies	help immune system support
		Aloe	relieve sunburn, minor cuts, dry skin
		Antidiarrheal	relieve symptoms of diarrhea
		Antifungal cream	relieve symptoms of itching and burning
		Benzocaine (Oral Gel)	toothache, canker sore, sore gum/mouth, mouth/gum injury
		Bismuth Subsalicylate (Pepto-Bismol, Kaopectate)	relieve indigestion
		Calagel	soothe minor skin irritations/itching
		Calamine Lotion	relieves itching, skin irritations
		Calcium Carbonate(TUMS, Rolaids)	relieves indigestion
		Canker melts	relieve symptoms of canker sores
		Cetirizine (Zyrtec)	seasonal allergies, mild allergic reactions
		Chlor-Tab	runny nose from allergies or cold, seasonal allergies
		Cough Drops	cough, sore throat
		Dayquil	cold/flu symptoms
		Deep Woods OFF	bug repellant
		Delsym	cough suppressant

		Diphenhydramine (Benadryl)	seasonal allergies, mild allergic reactions
		Docusate Sodium	relieves occasional constipation
		Famotidine (Pepcid)	relieves/prevents heartburn, acid indigestion
		Famotidine/Calcium/Magnesium (Duo Fusion)	antacid, acid reducer
		Fexofenadine (Allegra)	nasal congestion, sinus pressure, allergies
		Guaifenesin (Mucinex)	loosen mucus, clear congestion
		Hemorrhoid Cream/Wipes	relieves itching, burning, discomfort
		Hydrocortisone Cream 1%	minor skin irritations
		Ibuprofen (Aleve, Advil, Motrin)	relieve pain, reduce fever/discomfort/swelling
		Laxative	constipation
		Lice Shampoo (Nix, Rid)	lice treatment
		Loperamide Hydrochloride (Imodium AD)	help control symptoms of diarrhea
		Loratadine (Claritin)	seasonal allergies, mild allergic reactions
		Meclizine HCL (Dramamine)	prevent motion sickness
		Medicaine (Sting Swab)	relieve pain from insect bite/sting
		Muscle rub	sore muscles / joint pain
		Oral Rinse (Biotene)	soothe dry mouth
		Oxymetazoline Hydrochloride	nasal decongestant
		Phenylephrine (Sudafed PE)	nasal/sinus congestion, allergies
		Pseudoephedrine (Sudafed)	decongestant, stuffy nose, sinuses
		Pseudoephedrine HCL	decongestant, stuffy nose; sinuses
		Polyethylene Glycol (Miralax)	constipation
		Simethicone (Gas X)	relieves gas, pressure, bloating, discomfort
		Sun screen	protect against sun burn
		Sun Tan/Burn Relief	aloe & lidocaine for sun burn
		Throat Lozenges (Chloraseptic)	sore throat /cough
		Topical Antibiotic Cream	prevent infection / minor skin abrasions
		Tussin DM	relieves cough, chest congestion/mucus
		Visine / eye wash	relieve eye irritations
		Vitamin C Drop/Gummies	source of antioxidant, immune support defense

SIGNATURE of PHYSICIAN_____ Date_____

SIGNATURE of PARENT/GUARDIAN_____ Date _____

Grand River Academy
PersonalRx Information Form

PersonalRX is the contracted pharmacy of the Grand River Academy. They provide us with our medications and over-the-counter items, which includes vitamins, minerals, and/or supplements. All parents/guardians are required to register their student with PersonalRX whether or not they are currently on any medications. You can register online at www.personalrx.com or you can download the registration packet and either email, fax, or mail it to PersonalRX. Once you register your student with PersonalRX, they will provide any medications/over-the-counter items that your student needs, bill your insurance company using the insurance information you provide, and then bill you for any medication/over-the-counter items not covered by your insurance as well as any fees described below. PARTICIPATION IN THIS PROGRAM IS REQUIRED FOR ALL STUDENTS TAKING MEDICATION. For more information, please visit the PersonalRX pharmacy's Group Services website — www.personalrx.com

PersonalRX accepts over multiple insurance plans. Your insurance company determines your co-payment with PersonalRX. Please let them know if you have a particular state Medicaid and/or a 90-day mail order plan. If you have any questions regarding your insurance, please call PersonalRX at Please call PersonalRX with any questions at 201.399.3700 and they will help you with these issues or refer you to Grand River for further advice.

All medications/over-the-counter items dispensed to your student by our Health Center require physician orders. THIS FORM IS IN ADDITION TO THE PRESCRIPTION GIVEN TO PersonalRX. A copy of the Medication Administration Authorization form is available and must be signed by a physician and parent/guardian for all medications and over-the-counter items you authorize your student to receive while he/she is enrolled at Grand River.

Once an original prescription is received by PersonalRX, they will FedEx the medicine pre- packaged in individual dose packets. This method of dispensing medication will minimize potential medication errors insuring that every student gets the correct medication and dosage at the correct time every day. If a medication is added, discontinued, or a dosage changed, you must notify PersonalRX and our health center in writing before the change in medication can be completed. PersonalRX has provided a checklist of helpful things to help expedite medication delivery.

I have read and understand the above information (please sign below):

(Parent/Guardian) _____

Student Name_____Date_____

Register online at www.personalrx.com