



# ST. JOHNSBURY ACADEMY

St. Johnsbury Vermont, 05819 | Phone: (802) 748-8171 | Fax: (802) 748-5463 | [www.stjohnsburyacademy.org](http://www.stjohnsburyacademy.org)

Student Name \_\_\_\_\_

## Report of Health Evaluation 08-09 MUST BE COMPLETED BY A PHYSICIAN ANNUALLY

STUDENT'S LAST NAME \_\_\_\_\_ STUDENT'S FIRST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ YEAR OR GRADUATION \_\_\_\_\_ SEX:  F  M

### Urinalysis

Sugar \_\_\_\_\_ Hemoglobin or Hematocrit \_\_\_\_\_  
Albumin \_\_\_\_\_ Blood pressure \_\_\_\_\_  
Micro. \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Tuberculin Skin Test: Date \_\_\_\_\_ Type \_\_\_\_\_ BCG Date \_\_\_\_\_  
Result:  Negative  Positive Induration \_\_\_\_\_ mm  
Chest x-ray results \_\_\_\_\_ Date \_\_\_\_\_

**Please include copy of chest x-ray report.**

Is there sign or symptom of active tuberculosis? \_\_\_\_\_

Are there any chronic conditions that require treatment or periodic evaluation? \_\_\_\_\_

Please comment: \_\_\_\_\_

**Does the student have allergies?** \_\_\_\_\_

**Are there abnormalities of the following systems? Describe fully. Use an additional sheet, if necessary.**

	Yes	No		Yes	No
Head, ears, nose, throat	___	___	Genitourinary	___	___
Respiratory	___	___	Musculoskeletal	___	___
Cardiovascular	___	___	Metabolic/Endocrine	___	___
Gastrointestinal	___	___	Neuropsychiatric	___	___
Hernia	___	___	Skin	___	___
Eyes	___	___	Any other condition	___	___

**Are there any restrictions to physical activity or participation in a competitive athletic program?**  No  Yes

(Please list) \_\_\_\_\_

### Any known injury of or condition of:

Back \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_  
Knee \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_  
Shoulder \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_  
Head \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_  
Other injury \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_

## Report of Health Evaluation CONTINUED

List all medications and their dosages (including over the counter and supplements)

Medication	Dosage	Instructions
1.		
2.		
3.		
4.		
5.		
6.		
7.		

All medications are administered by the Health office. Please deliver them to the office upon your arrival to campus.

EXAMINING PHYSICIAN SIGNATURE

DATE

EXAMINING PHYSICIAN PRINT

DATE

MAILING ADDRESS:

STREET

STREET LINE 2

CITY

STATE

COUNTRY

ZIP CODE

( )

( )

BUSINESS PHONE WITH AREA CODE

FAX NUMBER WITH AREA CODE

E-MAIL ADDRESS

## SchoolMed PRE-PACKAGED MEDICATIONS FOR STUDENTS

Dear School Parents,

This coming school year, St. Johnsbury Academy will continue **requiring** school families to register for the service of **SchoolMed** to dispense and package all of your student's medication in pill form while at school. **All pills that your child takes on a daily or as needed basis** will be dispensed by our pharmacy and individually packaged, sealed, and sorted according to day and time of administration. **This includes prescription and non-prescription pills and vitamins.** Each packet will be labeled with your child's name, medicine, dosage, date, and time to be given. Our system ensures that each student receives the correct medicine at the correct time.

The pharmacy will dispense and ship all medicine in 30-day increments directly to the school on a monthly basis. The initial shipment of meds will be sent to the school prior to your child's arrival. You will be notified by e-mail when **SchoolMed** receives your initial prescriptions and when those meds are shipped to school.

### **What you need to do:**

1. Register on [www.SchoolMed.com](http://www.SchoolMed.com) – note your order number.
2. Print out receipt from on-line registration.
3. Get original prescriptions for ALL meds (prescription and non-prescription) written with enough refills for the entire school year.  
Bring enclosed Physician Instruction Letter.
4. **NOTE:** under law Controlled Substances may not be written with refills. A new prescription is required for each 30-day supply and **MUST** be sent to **SchoolMed** on a monthly basis. You are encouraged to send multiple 30-day prescriptions at a time. They will not expire, as the pharmacy is located in a state where they have up to 6 months to fill the prescription.
5. Make certain prescriptions are written exactly the way your child takes the medication.
6. Write the order number on top of each original prescription.
7. Include a copy of both sides of your insurance/prescription card that covers the meds.
8. Mail directly to: **SchoolMed**, P.O. Box 267037, Ft. Lauderdale, FL 33326-7037.

**Deadlines:** ALL OF THE ABOVE ITEMS MUST BE RECEIVED 30 DAYS PRIOR TO STUDENT'S START DATE.

**A late fee of \$25** will be charged to your credit card if any of the items above are received after the deadline.

You will be responsible for any shipping charges for any med that is unable to be shipped with the monthly refills due to **SchoolMed** not receiving prescriptions that may be needed.

**Insurance/Prescription Meds:** Our pharmacy partner accepts most insurance plans. They will verify your insurance and bill your insurance provider for prescription drugs. You will be responsible for co-payments and deductibles and the cost of drugs not covered by your plan. The pharmacy will not charge the initial medication charges to your credit card until after your child is in school. They will then charge your card every month that meds are sent to school. It is important that you notify **SchoolMed** of any changes to your credit card. If the pharmacy is **not** a provider for your plan, you will be notified and given the option to contact your school for alternative arrangements.

**Meds not covered by Insurance:** Will be charged to your credit card by the pharmacy.

Please refer to our website [www.SchoolMed.com](http://www.SchoolMed.com) for registration and details. For questions or if you are unable to register on-line, contact **SchoolMed** at 954-916-4990 or [info@SchoolMed.com](mailto:info@SchoolMed.com).