DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

INSTRUCTIONS: Please complete all forms in this packet and return to the School Health Center by fax at 518-794-6024 or e-mail – healthcenter@darrowschool.org. All forms must be received and reviewed by the Health Center, PRIOR to the student being approved to come to Campus. Due to legal reasons, Digital Signatures are NOT valid and cannot be accepted.

Health forms are completed annually before the start of each school year. The only exception is the Physical/Health Exam, which is good for a period of 12 calendar months. We ONLY accept physicals completed by your child's primary care provider – NO URGENT CARE.

The required forms/sections to complete are as follows (applies to BOTH Day Students and Boarding Students):
Permission to Treat
Health/Physical Form
Immunization Records
Students' insurance cards (front and back)
International Health Insurance Agreement (for international students)
Medical Leave Policy Agreement
Privacy Form
OTC Permission Form

The following forms are optional or needed only if applicable to the student:
Dental Exam Form (highly encouraged)
Order for Prescribed Medications (if the student takes prescription medication)
Health Care Provider & Parent Permission for Medications (if student has prescription medications)
Asthma Action Plan (if the child has asthma – please request form)
Diabetes Action Plan (if the child has Diabetes – please request form)
Food Allergy Action Plan (if the child has food allergies – please request form)
Seizure Action Plan (if the student has seizures – please request form)
Permission for independent use and carrying of rapid administration/rescue medication (only if the student takes these)
Student Medication Agreement (for students who self-administer medications, supplements, or vitamins)

Please pay close attention to the following:

1. **Personal Information**: Please note that full addresses and all telephone numbers are needed where a parent/guardian or designee may be reached in the event of an emergency.

2. **Permission to Treat**: This permission form is required by all emergency care facilities and healthcare providers before treatment will be given. Once you have filled in the top portion, please be sure to sign at the bottom.

3. **Insurance Information**: We require that all students carry health insurance. Please take a photo or scan of the front and back of the cards and upload them to EduHealth. If the student is found to no longer have health insurance, the student may be placed on a medical leave of absence until proof of insurance is confirmed. FOR INTERNATIONAL STUDENTS: If you are purchasing the school's international health insurance policy for your child, please indicate this on the form, and we will enter the ID# once it has been assigned. **Please remember to send us updates and/or changes to insurance/billing information during the school year.

4. **Physical Examination and Screening**: The **Primary Care Provider (MD, DO, PA, NP)** must sign and fill out this page for your child to be allowed to participate in team sports activities per New York State law and in non-team sports/physical education per Darrow School Policy. This exam must be completed annually (usually right after your child's birthday). **WE DO NOT ACCEPT PHYSICALS FROM URGENT CARE.** New York state law requires 9th-graders to have a scoliosis screening, and 11th-grade students must have hearing and vision screenings. Please be sure the medical history section is as accurate and complete as possible. When portions of your child's health history are left off these records, it is difficult to provide the best possible care for your child. If there is any relevant parental health history that our school healthcare team should know, please include it on the form and designate to which parent it applies.

5. **Dental Exam and Screening**: NYS now recommends that all students have a dental exam and screening, just as students must have an annual physical. Please have your child's dentist complete a dental exam. We do not send students for routine/annual dental care while at school. This should be done during a school break/vacation.

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

6. **Immunizations Record**: New York State enforces laws that refuse enrollment of any child who fails to comply with the immunization requirements of New York State. THIS IS NOT A DARROW SCHOOL POLICY, BUT NYS LAW. Please be sure that all of your child's immunizations have been recorded and are up to date according to New York State guidelines or that blood tests have been performed to prove immunity. Please have your provider review the form thoroughly. If you are claiming a medical exemption from immunization, please have the Provider fill out the form and submit it. Please note that New York State law no longer provides immunization exemptions for non-medical reasons (i.e., religious). The Department of Health and the American Academy of Pediatrics strongly recommend getting your child the flu vaccine every year. INTERNATIONAL STUDENTS must also meet all immunization requirements from NYS.

7. **Order for Prescribed Medications Form**: This form must be completed for all medications that your child has been prescribed. This form must be completed annually at the start of the school year and whenever there is a change to a medication. Each prescriber of medication must complete this form.

Darrow School is affiliated with several area providers for urgent care visits and consultations. Your insurance information will be forwarded to their office if services are needed. If you have copays or deductibles associated with your insurance, these payments will be withdrawn from your child's student drawing account if paid by Darrow School. However, it is preferred that each student has a form or method of payment available to them while here at Darrow School.

If your child will be taking prescribed medication, please choose a pharmacy that will mail or deliver medications to Darrow School Health Center (not the student), such as Caremark or Express Scripts. This is our preferred method. However, we will still accept prescriptions hand-delivered or mailed from parents to the health center. **Darrow Health Services does not refill, reorder, or pick up medications from the pharmacy (except for international students, prescriptions from an urgent care/ER visit, or those written by our School Medical Provider).** Health Services will notify parents that medication needs to be refilled through EduHealth. This notification will be sent when we have 10 days left of medication. This is a courtesy only, as parents/guardians remain responsible for monitoring their child's prescriptions and ensuring that they are refilled or reordered in sufficient time for the Health Center to receive them before running out.

*****Please note DO NOT send "as needed" over-the-counter medications (Ibuprofen, Acetaminophen, Claritin, cold medicine) to school with your child. The Health Center is stocked with common over-the-counter preparations.***

All medications, including vitamins or supplements, MUST be brought to the Health Center. Students must be able to self-administer all Vitamins and Supplements. Darrow School will administer only medications prescribed/authorized by the provider or the School Medical Provider. Boarding Students should arrive at School with a minimum of 1 month's supply of each medication (notify your pharmacy and provider that your child is attending a boarding school and ask for a 90-day supply – it may require an "override" by the insurance). ***Our School Medication Policy DOES NOT allow the self-administration of any controlled substance or behavioral health medications.***

******As per our policy, which will be enforced, no student will be allowed to come to campus or start classes until we have received ALL of your child's medical forms completed in full. Students arriving without completed medical forms may NOT be allowed to stay on campus and may need to be sent home until all forms are completed******

Please complete the forms in EduHealth, if possible. Paper forms will still be accepted and should be sent to the Darrow School Health Center. You may also fax these forms to 518-794-6024 or email them to healthcenter@darrowschool.org. If you need assistance or have questions, please contact Gerald Russell, Director of Health Services, by email at russellg@darrowschool.org. PLEASE SEND ALL FORMS AT ONE TIME AFTER EVERYTHING HAS BEEN COMPLETED.

To ensure your child is ready to come to campus for the School Year, the Health Center should receive ALL required forms before student arrival (BY AUGUST 11, 2025). This provides sufficient time for your forms to be reviewed by Health Services Staff and for you to correct any errors or incomplete forms.

Sincerely,
Darrow School Health Services Team

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

PERMISSION TO TREAT

Boarding or Day Student (circle one)

Student's Name _____ Age/Grade _____ Gender (M/F) _____ Date of Birth _____

Parent's Name: _____
Address: _____
Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____
E-mail: _____

Parent's Name: _____
Address: _____
Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____
E-mail: _____

Emergency Contact: _____
Address: _____
Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____
E-mail: _____

Primary Care Physician: _____
Address: _____
Fax: _____
Office Telephone: _____
Cellular Telephone: _____
E-mail: _____

I, _____, am hereby authorizing Darrow School's Health Services Center to provide general health care and counseling to_____, as needed, while attending Darrow School. I understand that this permission covers the Nurse(s), Counselor(s), Athletic Trainer(s). School Medical Provider(s) and area Physician(s), Dentist(s), Counselor(s), Psychologist(s), Clinic(s) or Hospital(s) to provide any of the following care: Medical counseling, General Health Maintenance, Group Counseling, Health Seminars, Evaluations-Psychological or Medical, Curative or Maintenance Counseling, Required Immunizations, Crisis Counseling, Emergency Medical or Psychological Care and possible admissions to area hospitals, as needed. This permission will also cover obtaining alcohol and drug screening and the results of such testing, as deemed necessary by Darrow School. I also give permission for my child to receive all mandatory or needed vaccinations to be in compliance with New York State Law.

I realize that in the event of an emergency, the Health Services Center will attempt to reach me or the emergency contact, so named, for verbal consent for treatment, and if both are still unavailable, I am authorizing any and all of the following: 1). Initial evaluation and commencement of treatment at the school; 2). Admission to area facilities (Hospitals, Crisis Centers); 3). Medications, as needed; and 4). Emergency treatment and /or surgery and anesthesia to perform emergency surgery. I understand that when emergency care has been given off school grounds, I will be contacted by the school or the facility utilized to report the outcome. However, I realize that when general medical care is given at Darrow Health Center, the student will report the results unless the Nurse feels it is more appropriate for them to do so.

I understand that I will be contacted, whenever possible, before initial counseling or evaluative appointments are made by the Darrow Health Center. I realize, however, that in the event of an emergency, I will be contacted as soon as possible, but that it may be afterwards. I further understand that the Counselor from Darrow Health Center will contact me by phone after initial consultation and periodically thereafter to discuss the student's status and schedule of appointments. I agree that the Counselor and the Health Services Staff will maintain confidentiality with the student, unless it is in some way contraindicated, at which time it will be broken only after the student has been informed of the same.

I agree to pay all appropriate billings on arrival and will obtain reimbursement from my health insurance company. I understand that the bills will be sent to the address noted herein as the responsible party not to Darrow School.

I agree that this permission will be considered binding by the school and all area facilities until my child has withdrawn or graduated from Darrow School and that if I choose to revoke this permission, I will contact the Health Services Director in writing. I further understand that this permission is a mandatory part of my child's Health Record and is necessary for continued enrollment at Darrow School.

Signature: _____ Relationship: _____ Date: _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To share protected health information, we require completion of the form below to comply with the requirements of the Healthcare Privacy Act or Laws. Please complete, sign, and give the form to your healthcare provider(s) and to the Darrow School Health Center to avoid delays in care for your child.

I, _____, authorize a healthcare provider(s) to release the medical records or information of _____, DOB _____ to Darrow School's: ❒ Health Center ❒ Athletic Trainer ❒ Counselor ❒ Teacher ❒ Dean of Students ❒ House Parent ❒ Advisor ❒ Coach

A healthcare provider may disclose the following information: (check all that apply)
❒ Any/All Records Requested ❒ Health Appraisals ❒ Imaging Studies ❒ Immunizations
❒ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/Student: check all that apply)
❒ To develop care or therapy plans for routine and emergent school management
❒ To design appropriate educational, school, or athletic programs
❒ To assess the impact of the medical condition(s) on school programming and/or attendance
❒ To share school observations/concerns surrounding behavior
❒ To assess a medical basis for modification of transportation and/or home tutoring
❒ Medication delivery or therapy prescriptions
❒ At the patient's request with no specified purpose
❒ Other_____

Parent/Student (if over 18): Please select one.
❒ This authorization is valid for the entire academic school year_20___-_20_____
❒ This authorization is valid for the duration of attendance at the Darrow School
❒ This authorization shall expire on ____/_____/_____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the Darrow School Health Services Director. I understand that the revocation of this authorization is not effective if the Healthcare Provider or School has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the Darrow School will share relevant information with my healthcare providers and, when applicable, with those governmental agencies as required for reimbursements. I permit the Darrow School representatives above to share and disclose information as indicated above with healthcare providers and among one another.

_____

Signature of Parent/Guardian (or student if over 18) Relationship Date

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

OTC PERMISSIONS BASED UPON STANDING ORDERS

These are the Over-the-Counter (OTC) medications that each student may have, as needed, per Darrow School Standing Orders. Please cross off those that you DO NOT permit for your child to be given while at Darrow School. Your signature below also indicates permission and understanding that Darrow Health Center may use generic or like forms of the below medications. ***If you do not wish to permit your child to be given medication listed below, please put a line through the medication.***

Acetaminophen (Tylenol)
Antacid (Tums/Pepcid)
Antibiotic Ointment (Bacitracin/Neosporin)
Antihistamine (Loratadine/Claritin/Benadryl/Zyrtec)
Betadine/Iodine
Calamine Lotion
Lubricating Eye Drops (Artificial Tears)
Expectorant (Guaifenesin/Mucinex)
Anti-Itch Cream (Hydrocortisone Cream)
Ibuprofen (Advil)
Oral anesthetic (Orajel)
Pepto-Bismol (Maalox or Mylanta)
Decongestant (Phenylephrine HCL/Sudafed)
Analgesic Cream (Bengay/Icy Hot)
Hydrogen Peroxide
Cough Drops
Antidiarrheal Medication (Imodium)
Laxative (Metamucil/MiraLax)
Naproxen Sodium (Aleve)
Burn Cream
Cough and Cold Pills
Cough Suppressant (Dextromethorphan)
Mucinex
(FEMALES ONLY) Menstrual Period Symptom Relief (Midol)

PLEASE CHOOSE ONLY ONE OF THE OPTIONS BELOW:

- ☐ I authorize the use of natural remedies when available.
- ☐ I DO NOT authorize the use of natural remedies.

Parent/Guardian Signature: _____ Parent/Guardian Name: _____
Date: _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

MEDICAL LEAVE POLICY AGREEMENT

Darrow School is committed to the safety of each student as well as the community as a whole. At times, treatment for certain physical or psychological disorders is best accomplished away from school. A medical leave may ONLY be approved by Health Services. The Director of Health Services may approve any form of medical leave. The School Counselor may approve medical leave for behavioral or psychological reasons. Health Services will determine whether and under what conditions a student should return to the School. It is the goal of Health Services to support students in their return to school as quickly as possible, while also ensuring that each student receives the care that they need and will be successful upon their return to school. Medical leaves are administrative rather than disciplinary; they are not intended to be punitive and do not take the place of disciplinary action that may occur. A medical leave is not intended nor will be able to stop or excuse disciplinary actions. Any staff or faculty member, student family member, or student may initiate a medical leave request by submitting a Medical Leave Request Form to either the Director of Health Services or the School Counselor.

I, _____, have read, understand, and agree to the terms outlined in the Darrow School Medical Leave Policy and Agreement. I understand that any violations of the Medical Leave Policy may result in disciplinary action, which can include dismissal. I also understand that I am not entitled to any compensation should my child be denied a return from medical leave.

Printed Name (parent/guardian)/ Student (if over 18)
Date

_____

Signature (parent/guardian)/ Student (if over 18)

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

SCHOOL HEALTH FORM

(This form will only be accepted if completed by your child's Primary Care Provider. We do not accept physicals from Urgent Care)

Name: _____ Pronouns: _____ DOB: _____
Biological Gender: M / F Preferred Gender: M / F Exam Date: _____

HEALTH HISTORY

Specify Current Health Conditions

- Diabetes*
- Seizures*
- Asthma*
- Allergies*

Action plan must be completed and attached for any of the above medical conditions.

Please list ALL current medications:

• Immunization Records attached Y / N
• A complete immunization record reported NYSIIS Y / N

Significant Medical/Surgical Information (ALL MEDICAL/MENTAL HEALTH DIAGNOSES MUST BE LISTED):

Please indicate any mental health diagnosis for which child is or has been treated for (e.g. ADHD, depression, anxiety disorder, bipolar, eating disorder, etc.) and treatment (e.g. counseling, medication, hospitalization, etc.)_____

Is there are current safety/suicide plan in place (if yes, please attach):

Currently treated by:_____
Physician Name Address

Please indicate whether child has any history of substance use • Yes • No: • Alcohol • Cigarettes/Tobacco

• Marijuana • prescription drug abuse • other drugs_____ • other substances_____

Please indicate any treatments, evaluations or recommendations made for history of substance abuse_____

Does this child follow a special diet or have any dietary restrictions? If yes, please specify:_____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

<table>
<tr><th colspan="6">PHYSICAL EXAM</th></tr>
<tr><td colspan="6">Height Weight: BP: Pulse: Respiration:</td></tr>
<tr><td colspan="3">Scoliosis: • Negative •Positive</td><td>Vision</td><td>Right</td><td>Left</td><td>Referral</td></tr>
<tr><td colspan="3">Degree of deviation:</td><td>Distance Acuity</td><td></td><td></td><td>• Yes • No</td></tr>
<tr><td colspan="3">Angle of trunk rotation via scoliometer:</td><td>Distance acuity with lenses</td><td></td><td></td><td></td></tr>
<tr><td colspan="3" rowspan="4">Body Mass Index:
Weight Status Category (BMI Percentile):
• <5th • 85th – 94th
• 5th – 49th • 95th – 98th
•50th – 84th • 99th & higher</td><td>Vision – Near Vision</td><td></td><td></td><td></td></tr>
<tr><td>Vision – color perception</td><td>• Pass</td><td>• Fail</td><td></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Hearing</td><td>Right</td><td>Left</td><td>Referral</td></tr>
<tr><td colspan="3"></td><td>• 20 db sweep screen both ears or</td><td></td><td></td><td>• Yes • No</td></tr>
<tr><td colspan="6">Circle developmental stage TANNER: • I • II • III • IV • V</td></tr>
<tr><td colspan="6">System Review and Abnormal Findings Listed Below</td></tr>
<tr><td colspan="6">• HEENT • Lymph nodes • Abdomen • Extremities • Speech
• Dental • Cardiovascular • Back/Spine • Skin • Social Emotional
• Neck • Lungs • Genitourinary • Neurological • Musculoskeletal
• Normal Exam</td></tr>
<tr><td colspan="3">• Assessment/Abnormalities Noted/Recommendations:</td><td colspan="3">Diagnoses/Problems (LIST ALL MEDICAL/MENTAL HEALTH DIAGNOSES HERE)</td></tr>
</table>

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION
(check all that apply)

- o Family cardiac history has been reviewed as required by the Dominick Murray Sudden Cardiac Arrest Prevention Act (this MUST be completed for the Physical to be Valid in NYS)
- o Physically qualified for all sports or full playground
- o Not qualified for full participation. May ONLY participate in the areas circled below.
- o Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo
- o Limited contact/Endurance: baseball, cross-country, field events, floor hockey, gymnastics, handball, skiing, softball, swimming, track, ultimate Frisbee, volleyball
- o Non-Contact: archery, badminton, bowling, crew, dance, golf, jump rope, rifle team, table tennis, ten, walking, weights
- o Physically qualified for employment, OR specify accommodation_____
- o Specific Restrictions_____

Provider's Signature:_____ (physical signature or official stamp only)

Provider's Name: _____

Providers Address/Phone/Fax:_____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

OPTIONAL / IF APPLICABLE FORMS

MANDATED HEALTH CARE AGREEMENT (INTERNATIONAL BOARDING STUDENTS ONLY)

Out of concern for the health and welfare of all our students, Darrow School requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by local providers and practitioners. Please note that our health center will not accept medical insurance policies issued in a foreign country or from a company outside the United States.

To help you meet your financial responsibilities, we offer a comprehensive plan that includes health, limited dental, and vision. This plan provides primary, first-dollar benefits for those of you who do not have any insurance or whose coverage is not accepted outside your geographical area. This plan will cover students anywhere in the world, except their home country
Country, for a full 12-month period, $3,040 or 10 months, 8/15/2025- 6/14/202,6 for a premium of $2,715. This plan was designed especially for private secondary schools. Students who arrive mid-year will be placed on a daily plan for $10 per day. **ALL INTERNATIONAL STUDENTS MUST ENROLL IN THE PLAN**. The basic provisions and exclusions of this plan are outlined in the insurance summary, which may be requested from the school. Certificates with further
details will be issued to every participant along with a personal identification card. You must select one of the three options provided below. Please note that this is an addendum to your Enrollment Agreement, and both your Agreement and this Addendum must be returned to the school.

Please check the appropriate boxes below, include the student's name, sign your name, date, and return promptly to the Health Center.

2025-2026 STUDENT INJURY & SICKNESS PLANS

☐ Enroll in plan for 12 months ($3,040 for 8/15/2025-8/14/2026)

☐ Enroll in plan for 10 months ($2,715 for 8/15/2025-6/14/2026)

☐ Enroll in the plan on a daily rate ($10.00 for the date of arrival to 8/14/26)

Parent/Guardian Signature: _____ Date: _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

MANDATED HEALTH CARE AGREEMENT (INTERNATIONAL DAY STUDENTS ONLY - ACA)

Out of concern for the health and welfare of all our students, Darrow School requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by local providers and practitioners. Please note that our health center will not accept medical insurance policies issued in a foreign country or from a company outside the United States.

To help you meet your financial responsibilities, we offer a standard plan for health coverage only. This plan provides primary, first-dollar benefits for those of you who do not have any insurance or whose coverage is not accepted outside your geographical area. This plan will cover students anywhere in the world, except their home Country. This plan was designed especially for private secondary schools and for our International Day Students ONLY. **ALL INTERNATIONAL DAY STUDENTS MUST ENROLL IN THE PLAN**. The basic provisions and exclusions of this plan are outlined in the insurance summary, which may be requested from the school. Certificates with further details will be issued to every participant along with a personal identification card. Please note that this is an addendum to your Enrollment Agreement, and both your Agreement and this Addendum must be returned to the school.

Please check the box below, include the student's name, sign your name, date, and return promptly to the Health Center.

2025-2026 STUDENT INJURY & SICKNESS PLAN

☐ I authorize Darrow School to enroll my student into the Health Plan as described above.

Parent/Guardian Signature: _____ Date: _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

PERMISSION FOR INDEPENDENT USE AND CARRY OF RAPID ADMINISTRATION/RESCUE MEDICATION

Medical Provider Permission for Independent Use and Carry of Rapid Administration/Rescue Medication

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school or school-sponsored activity. This order applies to the medication(s) checked below:

The student is diagnosed with:
☐ Allergy and requires an Epinephrine Auto-injector
☐ Asthma or respiratory condition and required Inhaled Respiratory Rescue Medication
☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies

Which requires rapid administration of (Medication Name): _____

Provider Signature: _____Date: _____

Parent/Guardian Permission for Independent Use and Carry of Rapid Administration/Rescue Medication

I agree that my child can use their medication effectively and may carry and use this medication independently at any school or school-sponsored activity. Staff intervention and support may only be needed in an emergency.
Parent/Guardian Signature:
Date:

I give permission for medication(s) to be administered to my child as ordered by their healthcare provider. I am aware and agree that a Nurse or trained unlicensed assistive personnel will administer medications to my child. I will furnish all medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. I understand that I am solely responsible for monitoring, ordering, and refilling my child's medications in a timely manner so that they do not run out of medication while at School. I am aware that the preferred method to provide medication is through a mail order pharmacy, but I may choose a method of choice to provide medication to the School Health Center. I also understand that my child may be sent home on a Medical Leave of Absence if I am unable to supply medication as ordered by healthcare providers.

Parent/Guardian Signature: _____
Date _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

PERMISSION FOR SELF-ADMINISTER/SELF-CARRY FOR PRESCRIPTION MEDICATIONS
(STUDENT MUST COMPLETE THIS FORM AND SIGN)

Parent permission and healthcare provider consent are required for students to self-administer and self-carry prescription medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the Nurse or other designated Staff member. Parents assume full and sole responsibility for ensuring that their child is taking their medication as ordered. ***The Director of Health Services may revoke any self-carry/self-administer privilege if the student proves to be irresponsible or incapable of managing their medications.*** To request this option of self-carry/self-administer for your child, please sign below.

Please note that School Policy DOES NOT allow students to self-administer controlled substances or behavioral health medications.

Parent/Guardian Signature: _____Date: _____

Provider Signature: _____
Date: _____
Provider Name, Telephone Number, and Address: _____

STUDENT MEDICATION AGREEMENT

I, _____, acknowledge and agree (conditional to parental consent, if under 18) to store and take the below-listed medication as prescribed and per School Policy. I agree not to dispense the medication to anyone other than myself and understand that it would nullify this agreement and subject me to disciplinary action, as specified in the student handbook, but that may include dismissal. All medications that I have in my room are listed below. If I receive additional supplements/medications, I will bring them to the Health Center and have them reviewed, and if appropriate, added to this agreement.

Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____
Medication/Vitamin/Supplement: _____

I have read and agree to the above medication agreement.

Student Name _____ Date _____
Student Signature _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

ORDER FOR PRESCRIBED MEDICATIONS

Prescriber: Please complete and sign the following medication order(s) for any medication(s) that the indicated student will be taking during the school year at Darrow School. Darrow School is a Boarding School where students reside full-time throughout the school year. The School allows students to self-administer rescue medications, vitamins, and supplements. All other medications designated for self-administration will be decided on an individual basis. We DO NOT allow self-administration of controlled substances or behavioral health medications.

There are three (3) functional categories for medication administration: Nurse Dependent, Supervised, and Independent. If a student needs medications at a specific time, they must be Independent with medication administration. Please note that Nurse Dependent students may be assisted with taking their medication by trained unlicensed school personnel. Please send updated copies with any medication changes made throughout the school year to our email: healthcenter@darrowschool.org or fax (518) 794-6024.

STUDENT:_____ D.O.B.: _____

ALLERGIES:_____

PRESCRIBER NAME AND TITLE (please print): _____

PRESCRIBER ADDRESS: _____

PRESCRIBER OFFICE PHONE AND FAX: _____

Prescriber, please use the codes below for each medication ordered:

Nurse Dependent — I assess this student's function category as Nurse Dependent. They are unable to self-administer medication and cannot be considered in need of supervision according to the criteria for supervised students (listed below), and are therefore dependent on another person administering the medication to them. These students must have their medication administered to them by an appropriate licensed health professional or trained unlicensed personnel of the School.

Supervised — I assess this student's function category as supervised regarding their medications. They are able to administer medications to themself via the correct route; they are able to identify the correct medication, purpose, dosage, and time; they know the parameters or conditions under which the medication is to be taken and will refuse to take it medication if the parameters or conditions are not met; they are able to describe what will happen if medication is not taken, and they will refuse to take medication if there are questions or concerns about its appropriateness

Independent — I have determined this student's functional category is Independent regarding their medications. They are able to self-administer their own medications without any assistance. Their medications will be kept in the health office and dispensed by the Nurse to the student, in a 1-week supply.

Medication Name & Dose: _____

Route: _____ Frequency: _____ Time:_____

Diagnosis medication is prescribed for: _____

Remarks or Special Instructions: _____

❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only

Signature: _____ Date: _____

Medication Name & Dose: _____

Route: _____ Frequency: _____ Time:_____

Diagnosis medication is prescribed for: _____

Remarks or Special Instructions: _____

❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only

Signature: _____ Date: _____

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

Medication Name & Dose: ____________________
Route: ____________ Frequency: ____________ Time:________
Diagnosis medication is prescribed for: ____________________
Remarks or Special Instructions: ____________________
❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only
Signature: ____________________ Date: ____________________

Medication Name & Dose: ____________________
Route: ____________ Frequency: ____________ Time:________
Diagnosis medication is prescribed for: ____________________
Remarks or Special Instructions: ____________________
❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only
Signature: ____________________ Date: ____________________

Medication Name & Dose: ____________________
Route: ____________ Frequency: ____________ Time:________
Diagnosis medication is prescribed for: ____________________
Remarks or Special Instructions: ____________________
❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only
Signature: ____________________ Date: ____________________

Medication Name & Dose: ____________________
Route: ____________ Frequency: ____________ Time:________
Diagnosis medication is prescribed for: ____________________
Remarks or Special Instructions: ____________________
❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only
Signature: ____________________ Date: ____________________

Medication Name & Dose: ____________________
Route: ____________ Frequency: ____________ Time:________
Diagnosis medication is prescribed for: ____________________
Remarks or Special Instructions: ____________________
❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only
Signature: ____________________ Date: ____________________

Medication Name & Dose: ____________________
Route: ____________ Frequency: ____________ Time:________
Diagnosis medication is prescribed for: ____________________
Remarks or Special Instructions: ____________________
❑ Independent ❑ Supervised ❑ Nurse Dependent ❑ School Days Only
Signature: ____________________ Date: ____________________

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

Annual Influenza (Flu) Vaccine Consent Form

Section 1: Information about Student to Receive Vaccine (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER** **M / F / X**
ADDRESS				**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**			
STUDENT'S DOCTOR'S NAME (Last, First)	**Address**	**City**	**Zip**		
SCHOOL NAME **Darrow School**	**HOUSE/DORM**		**GRADE**		

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.
Please mark YES or NO for each question.

	YES	**NO**
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies? Please list: _____		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:
I have read or had explained to me the 2025-2026 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to Darrow School and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then your child will not be vaccinated).

I DO NOT GIVE CONSENT to Darrow School and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Date: month_____day_____year_____

Section 4: Vaccination Record (to be completed by Vaccine Administrator)

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Route**	**Date Dose Administered**	**Vaccine Manufacturer**	**Lot Number**	**Name and Title of Vaccine Administrator**
Influenza	IM	/ /			

DARROW SCHOOL HEALTH FORMS PACKET
2025-2026

MEDICAL ACTION PLANS

Medical Action Plans are required to be completed by your child's medical provider if your child has any of the following conditions: Asthma, Diabetes, Allergies (i.e., bees), Seizures, or Food Allergies. These forms can be located at our School Website with the rest of our medical forms, OR you can obtain the forms from your child's healthcare provider.