Parent Permission for Medical Treatment

Army Navy Academy
Parent or Guardian to Complete

Cadet Name | Date of Birth

Parent Name

I hereby give permission to the medical personnel selected by the Academy and/or its authorized representative to do any of the following as needed or required: administer medication, order x-rays, order routine tests, render treatment, provide or arrange necessary related transportation for my cadet, and obtain and release medical information as necessary.

In the event that the parent or guardian cannot be reached in an emergency, I hereby give permission to the physician selected by the Academy and/or its authorized representative to secure and administer treatment, including hospitalization, for the cadet on this form.

I authorize any hospital or health care practitioner rendering necessary care (under the circumstances) for the cadet named on these forms to provide copies of medical records and to share clinical information with the Academy and/or its authorized representatives. This entire completed form may be photocopied for trips, Army Navy athletic teams or emergencies off campus.

Your agreement below indicates you have read, understand, and will abide by the above policies of the Army and Navy Academy Health Center:

Parent Signature | Relationship to Student | Date

Health Center Registration
Notice of Privacy Practice

DOB
____/____/____

CADET Last Name | CADET First Name | CADET ID#

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING.

The Army Navy (AN) Health Center, as a "provider" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), complies with all regulations designed to protect the privacy of individual health information.

Understanding Your Health Record/Information—A record is made of every visit to a health care provider, including the AN Health Center. Typically this record contains the patient's symptoms, examination/test results, diagnoses, and treatment. This medical or health record is used to plan patient care and permit communication among health professionals, to document care received and verify services provided, to provide data for public health officials, and to improve health services.

Your Health Information Rights—Although the health record is the physical property of the AN Health Center Care or the entity that compiled it, the information belongs to the patient. As the patient's legal guardian you have the right to request a restriction on certain uses and disclosures, to obtain a copy or to request (in writing) to amend the record, to obtain an accounting of disclosures, to request communication of the health information by alternative means, and to revoke your authorization to use/disclose health information except to the extent already done.

The AN Health Center Responsibilities—We are required by law to maintain the privacy of your personal health information and to provide you with this Notice of our legal duties and privacy practices with respect to your personal health information and to have you sign a written acknowledgment that you received this Notice. You will be notified if the AN Health Center is unable to grant requested restrictions, and accommodate reasonable requests to communicate health information by alternative means or at alternative locations. The AN Health Center will maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard personal information. The AN Health Center may disclose information for law enforcement purposes as required by law or in response to a valid subpoena. Persons violating the schools Privacy Policy will be subject to disciplinary procedures. The AN Health Center reserves the right to change its practices regarding protected health information, in which case a revised privacy notice would be emailed or mailed to the address you have supplied.

Uses and Disclosures of Health Information— The AN Health Center personnel will use or disclose patient health information only as needed in treatment, payment, and health care operations. In particular The AN Health Center may, without specific additional authorization, disclose the patient's health information to any health care provider treating or otherwise rendering professional services to the patient and/or to insurers as necessary to facilitate payment for the patient's health care. Health care providers may, without specific additional authorization, disclose information to The AN Health Center as needed for the patient's care and treatment. With the exceptions described in this notice and as provided by law, The AN Health Center will not use or disclose health information without authorization. We may disclose your protected health information in the following situations without your authorization:

- As required by Judicial or Administrative Proceedings or law enforcement officials– we may disclose your protected health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or grand jury or administrative subpoena.
- Public Health Activities – We may disclose your protected health information to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability.
- Victims of Abuse, Neglect or Domestic Violence – If we reasonable believe you are a victim of abuse, neglect or domestic violence, we may disclose your protected health information to a governmental agency, authorized by law to receive reports of such abuse, neglect or domestic violence.
- Health Oversight Activities – we may disclose your protected health information to a health oversight committee ensuring compliance.
- Specialized Government Functions – We may disclose your protected health information to units of the government with special functions, such as the U.S. Military or the US Department of State.

For More Information or to Report a Problem—If you have questions, please contact the Infirmary at 760-547-5213. If you believe privacy rights have been violated, you have the right to file a complaint with the Department of Health and Human Services (877-696-6775). The AN Health Center will not retaliate for filing a complaint.

Acknowledgement of Authorization to Use and Disclose Health Information

I understand and agree that by enrolling at Army Navy the cadet named in this Health Form, and by my signature below, I authorize the AN Health Center personnel to use and disclose the patient's protected health information as needed in treatment, payment, and health care operations. The AN Health Center personnel may, without my specific authorization, disclose the patient's health information to any health care provider treating or otherwise rendering professional services to him and to insurers as necessary to facilitate payment for services. I understand that information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status. I understand that I may revoke this authorization at any time by written notice to AN Health Center. I have read the above and have received a copy of this Notice of Privacy Practice.

Signature of Parent or Guardian: _____ **Date:** _____

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Heath Center - Physical Exam Form

CADET Last Name _____ CADET First Name _____ CADET ID# _____

PHYSICIAN EXAMINATION

Complete a thorough review of systems. Please indicate fields are within normal limits (WNL) or describe abnormalities in detail.
Any necessary treatment or referrals should be completed *prior* to attendance.

All physicals must be on this form, translated in English.

- **Exam must be completed every 12 months by a licensed medical practitioner**
- **International Cadets Requirement**: *Yearly* TB Mantoux Test & CBC/Urinalysis (first year cadets only)

Recommended: Meningitis vaccine is highly recommended due to the boarding school environment.

Height _____	Weight _____	Blood Pressure _____	Pulse _____
Head _____	Eyes _____	Ears _____	Nose _____
Throat / Mouth _____	Neck _____	Thyroid _____	Neurological _____
Lungs _____	Heart _____	Abdomen _____	Genitalia / Hernia _____
Back _____	Shoulder / Arm _____	Extremities _____	Elbow / Forearm _____
Wrist / Hand _____	Hip / Thigh _____	Knee _____	Leg / Ankle _____
Foot _____	Skin _____	BMI _____	Nutritional Status _____
Anxiety _____	Depression _____	ADD/ADHD _____	Other Psych Problem _____

VISION: R 20/___ L 20/ ___ Corrected: Yes ___ No ___ Comments: _____

HEARING: Within Normal Range: Yes ___ No ___ Abnormalities? _____

MEDICATIONS: Does the student take any medication including routine, OTC'S, and supplements? ☐ Yes ☐ No *If Yes, complete Med Authorization Form

***SPORTS PARTICIPATION: Is the student cleared for participation in sports (MANDATORY Check one):** ☐ **Yes** ☐ **No**

Please describe in detail any condition which would prevent or limit full participation in all areas of athletics, marching, rifle drill, or academics. State diagnosis, prognosis, and specify duration (including dates) of any limitations or restrictions: _____

_____

Treatment to be continued while at school: _____

IMMUNIZATIONS

A copy of the immunization record is mandatory for admission. Please review students' immunization record and administer any vaccines needed prior to registration to adhere to the California State guidelines [**Tdap immunization required**].

Date of last pertussis booster: ____/____/____ **Chicken pox (disease)?** ☐ Yes ☐ No

1. TB MANTOUX TEST: (Yearly for International Students)
Please administer a yearly TB test if the patient has not had one within the last year from the date of projected enrollment at Army Navy Academy

Date of test: ___/___/___ Date results were read: ___/___/___ mm induration: _____ ☐ Pos* (>10mm) ☐ Neg

***Chest X-Ray: Necessary if skin test is positive**

Film Date: ___/___/___ Impression: ☐ Normal ☐ Abnormal Person is free of Communicable Tuberculosis: ☐ Yes ☐ No

2. CBC & UA (For 1st Year Internationals): (Please Attach Results)

Results WNL ☐ Yes ☐ No If no, abnormalities: _____

I have examined the above student on this date: ___/___/___ **Office Stamp and/or Seal:**

Practitioner's Signature: _____

Printed Name: _____ **Title:** _____

Address: _____

Phone: _____ **Fax:** _____

Form A: 12-2012

Immunization Record

Army Navy Academy

Student Name Date of Birth

Statement such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission may be denied on the basis of this information

Vaccine	Date Administered *Month/Day/Year*			
	One	Two	Three	Four
OPV / IPV (Polio) 4 doses: 3 if one was on or after the second birthday				
DTP/DT/Td / DTaP (Tetanus) 4 doses: 3 if one was on or after the second birthday. If last dose was before second birthday td booster is needed				
DTaP, DTP, Adacel, Tdap, Boostrix (Grade 7) 1 booster dose of Tetanus/Pertussis				
MMR 1 dose on or after 1st birthday 2nd dose at least 4 weeks after dose 1				
Varicella (Chickenpox disease) 1 dose up to 12 years 2 doses 12 years and older				
Hepatitis B 3 doses				

The California School Immunization Law allows a child to be exempt from the immunization requirements for personal beliefs or medical reasons. If your child is exempt from immunization, please let us know and we will provide you

I certify that the immunization dates are true to the best of my knowledge. Complete if this student is a new enrollee to the school or if additional immunizations have been given this year.

Physician Signature Title Date

Health Center Registration
Medication Authorization

CADET Last Name _____ CADET First Name _____ CADET ID# _____

This form MUST be completed and signed by a physician for ALL cadets taking medication, including routine, over the counter, vitamins, and supplements along with the office stamp and/or seal.

Cadets are not allowed to self-medicate or possess supplements or medications in room—see Dismissal Offenses and Zero-Tolerance Drug Policy Covenant.

No muscle building, performance enhancing substances may be taken!

Please list ALL medications (including vitamins, over-the-counter, and nonprescription drugs) taken. Please provide the Health Center with a **physician's signature** for all your medications. Keep medications in the original packaging/bottle that identifies the name of the cadet, the prescribing physician (if a prescription drug), the name of the medication, the dosage, the RX number, and the frequency of administration. An original prescription for each medication must be provided to GroupRx. Refills are then handled by GroupRx through contact with prescribing physician.

Exception: All Kaiser prescription medications must be delivered to the Health Center with the entire prescribed number of pills in the bottle. We do not handle these refills.

Prescription medications for ADHD, depression, and other medications used to treat psychological conditions, must be carried or sent via FedEx to Health Center. Individual prescriptions for each controlled substance must be submitted to GroupRx.

Any changes or discontinuation in medication regime during the school year must be written by the practitioner. Changes in prescriptions may be faxed directly to the AN Health Center at 760-434-1027 AND GroupRx at 201-334-0700

MEDICATION	DOSE/ROUTE	FREQUENCY (Pls "✓" admin times) 7AM	12PM	3PM	6PM	9PM	PRN	REASON FOR USE

Please provide any special instructions, for example: "*Cadet may refuse medication on weekends or evenings, or student may NOT refuse*".
If a new medication is replacing another, please provide the discontinuation order.

Special Instructions: _____

_____

Discontinuation Order: _____

_____

Prescribing Practitioner's Signature: _____ **Date:** _____

Print Practitioner's Name: _____ **Title:** _____

Address: _____

Phone: _____ **Fax:** _____

Office Stamp and/or Seal: