Visiting STUDENT Parental Checklist
Medical Forms Required to Visit Shepherds College

Forms to be completed by **Parent/Guardian/Student:**

- ☐ Medical Fact Sheet
- ☐ Doctor Information Sheet
- ☐ Release of Medical Information Consent
- ☐ Medication Administration Consent
- ☐ Authorization for Treatment/Care
- ☐ Copy of Insurance Card & Insurance Coverage (can be done at time of check-in)

Forms to be completed/SIGNED by **Physician:**

- ☐ Physical Exam – must be within 12 months of the scheduled overnight visit. A TB test is not required for C4W, but is required of all 1st year students and must be done within 90 days of opening weekend.
- ☐ Medication List (including all as needed and over the counter medications)
- ☐ Shepherds College PRN Medication List
- ☐ Immunization Requirements Form/Copy of Immunization Record
  - Required for the overnight visit: **Hepatitis B** and **Tetanus**.
  - Immunizations that will be required prior to enrollment include: MMR, Meningococcal Conjugate vaccine, B Meningococcal vaccine (MenB), Polio, Pertussis, and Varicella

Medical Fact Sheet

Date: _____

Student's Name: _____ Date of Birth: _____

Gender: M / F S.S. #: _____-_____-_____

Current Home Address: _____
Street City State Zip Code

Home Telephone #:_____ Cell Phone: _____

Student is their own Guardian: Y / N (If no please complete Guardian information below)

Name of Guardian: _____ Relation to Student: _____

Address: _____
Street City State Zip Code

Work Telephone: _____ Cell Phone: _____

Email: _____

Parent Contact Information

Father's Name: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip Code

Mother's Name: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip Code

Emergency Contact

Name: _____ Relation to student: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Doctor Information Sheet

Primary Care Doctor

Provider Name: _____

Facility/Company: _____

Address: _____
Street City State Zip Code

Office Phone number: _____

Office Fax Number: _____

Specialty Care Doctors (i.e. neurologist, endocrinologist, psychiatrist, etc.)

Provider Name: _____ Specialty: _____

Facility/Company: _____

Address: _____
Street City State Zip Code

Office Phone number: _____

Office Fax Number: _____

Provider Name: _____ Specialty: _____

Facility/Company: _____

Address: _____
Street City State Zip Code

Office Phone number: _____

Office Fax Number: _____

Provider Name: _____ Specialty: _____

Facility/Company: _____

Address: _____
Street City State Zip Code

Office Phone number: _____

Office Fax Number: _____

Annual Release of Medical Information Consent

I hereby request and authorize,

Doctor's Name: _____

Facility: _____

Address: _____
Street

_____
City **State** **Zip Code**

Phone: _____

Fax: _____

to release medical, dental, school, or psychiatric records including behavior management programs, vocational training assessments, and the most recent employment records for _____.
(Student's Name)

For the purpose of fulfilling admissions requirements and continued medical support while a student at Shepherds College. This information will be released to:

Shepherds College
Attention: Admissions Director & Nursing Department
1805 15th Avenue
Union Grove, WI 53182-1597
Phone: 262-878-6359 Fax: 262-878-3402

This consent shall remain effective until revoked in writing by me. If not previously revoked by me, this consent shall terminate upon the occurrence of any of the following events: (a) my death; (b) determination of a court of competent jurisdiction that I am incompetent; (c) written notification from me or my attorney to the above named provider that such consent is revoked; or (d) one year from the day that I have executed this agreement.

Dated this _____ day of _____ 20_____.

Signature of Parent/Guardian _____

Signature of Student _____

A photocopy of this document shall be as valid as the original.

Annual Medication Administration Consent

Shepherds College has my permission, as the student and parent/guardian, to have a trained staff give _____ medications prescribed by his/her doctor and any over-the-counter
(Student)
medications, supplements (including vitamins, nutrients, or herbals), and medications listed on our PRN medication list that is signed by the physician, while student is at Shepherds College.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date

Annual Authorization for Treatment/Care

The Parent(s)/Guardian(s) of _____ hereby authorize Shepherds College to secure and have performed any routine or emergency medical, dental, and surgical care, including, but not limited to vaccinations, immunizations, and physical or psychological examinations as Shepherds College deems necessary for the well-being of _____.

(Student)

(Student)

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian Date

Physical Exam

(Required Yearly)

Name: _____ DOB: _____ Date: _____

Date of Physical Exam: _____

Allergies (Medications, Environment, & Food):_____

Medical Diagnoses: _____

Medical History: _____

Any History of Seizures? Y / N If yes, when was the last seizure? _____

Any History of Diabetes? Y / N If yes, insulin used? _____

Diet / Diet Restrictions: _____

Height:_____ Weight: _____ Resp: _____ HR: _____ B/P:_____

Assessment	Normal	Abnormal	Comments if Abnormal
General Appearance			
Integumentary/Skin			
Head/Neck			
ENT			
Respiratory			
Cardiac			
Abdominal			
GI (gastrointestinal)			
Lymphatic system			
Musculoskeletal			
Neurological			
Psychological			
Males:			
Testicular / Prostate			
Female:			
Breasts			

_____ _____

Physician's Signature Address City State

_____ _____ _____

Physician's Name (Please Print) Phone Number Fax Number

Medication List

Name _____ D.O.B._____ Date _____

ALL prescription medications, **over-the-counter** medications, and **supplements** including; vitamins, nutrients, minerals, and herbals must be listed below and signed for by a Physician to be administered.

Name of Medication, OTC, Vitamin, or Supplement	Strength	Dose	Frequency	Route	Time Given

I certify that the medications listed above are correct to the best of my knowledge.

Physician's Signature _____ Date_____

Name of Physician (Printed) _____

Phone: _____ Fax: _____

Shepherds College PRN Medication List

(Supplied by Shepherds College)

MAY SUBSTITUE BRAND NAME/OVER-THE-COUTNER MEDICATIONS WITH GENERIC

Student's Name: _____ Date: _____

Reason	Medication	Dose/Route
Allergies/Rash	Diphenhydramine (Oral)	Use as directed on package
Cold Symptoms/ Cough	Guaifenesin 400 mg	Use as directed on package
	Delsym (dextromethorphan Polistirex)	Use as directed on package
Fever/Pain	Acetaminophen 325mg or 500mg	1-2 tabs by mouth every 4-6 hours as needed for pain or fever
	Ibuprofen 200 mg	1-2 tabs by mouth every 4-6 hours as needed for pain or fever
First Aid	Triple Antibiotic Ointment	Use as directed on package
	Hydrocortisone Cream	Use as directed on package

_____ _____

Physician Signature Physician Name (please print)

Immunization Requirement Form

Shepherds College and WI state law requires students attending school and living on campus in the dormitory or residence housing to be immunized against certain communicable diseases. To comply, please have this Immunization Requirement Form completed by your health care provider/medical office personal and submit before Shepherds College campus opening weekend.

The only circumstances under which a student may be exempt from these regulations are as follows:

1. The student provides written certification by an examining physician that the student's health would be endangered by one or more of the immunizations. (If the student is not immunized, the student will be excluded from classes in the event of an outbreak.) OR
2. The student provides a signed written statement that the required immunizations would conflict with his or her religious beliefs. (The student will be excluded from classes in the event of an outbreak.)

Please indicate immunizations with dates. If an immunization is not given for medical reasons, please attach a signed statement with reason for exemption.

Immunizations

	Date	Date	Date	Date
MMR	#1	#2		
Hepatitis B Series	#1	#2	#3	
Meningococcal Conjugate vaccine	#1	#2		
B Meningococcal vaccine (MenB)	#1	#2		
Tdap (Tetanus-Diptheria-Pertussis)		(within last 10 years)		
Polio	#1	#2	#3	#4
Varicella	#1	#2	☐ Had Chicken Pox	

☐ Immunization exemptions, see signed immunization wavier.

_____ _____

Health Care Professional/Physician Signature Date

_____

Health Care Address & STAMP