Lyndon
INSTITUTE

# Medical Release Form

I (We), ______________________________________________________________ ,
PARENT(S) OR LEGAL GUARDIAN(S) NAME(S)

the Parent(s) or Legal Guardian(s) of ______________________________________ ,
STUDENT NAME

a student in the Boarding Program or Summer Program at Lyndon Institute, do hereby give my permission to Lyndon Institute to:

- have the above-named student immunized to comply with state and/or school regulations, as needed;
- administer and/or obtain emergency and routine medical treatment as deemed appropriate and/or necessary by Lyndon Institute;
- order X-rays, routine testing, treatment, therapy, and all other health care needs; and
- administer, under the supervision of a legally-qualified nurse and/or delegate, any medications that have been prescribed by a physician for the above-named student.

I (We) also grant consent for the medical providers treating my child/ward to provide any and all Protected Health Information (as defined under HIPAA) about my child/ward to representatives of Lyndon Institute's Residential Life Program and Lyndon Institute's health insurance carrier.

I We) hereby release said medical providers from any and all claims arising out of or otherwise relating to any such disclosure of my child's/ward's Protected Health Information.

I (We) hereby release and discharge Lyndon Institute, including all of its employees, from any and all claims, demands, causes of action, damages, and liabilities, of whatever kind or nature, that may arise out of or be related to any of the items outlined above.

I (We) agree to pay all expenses associated with the items outlined above, which I (we) understand are not covered by insurance or in any other way.

______________________________________________________________________________

SIGNATURE OF PARENT(S) OR LEGAL GUARDIAN(S) DATE

Lyndon INSTITUTE

# Physical Examination Report

*Must have been completed by attending physician within the past 12 months.*

*Return completed report to Lyndon Institute Admissions Office, College Road, P.O. Box 127, Lyndon Center, VT 05850*

STUDENT'S FIRST NAME | MIDDLE INITIAL | LAST NAME | DATE OF BIRTH (MONTH/DAY/YEAR) / /

HEIGHT | WEIGHT | BLOOD PRESSURE | BLOOD TYPE | HEMOGLOBIN

TUBERCULIN SKIN TEST POSITIVE ☐ (If positive, report of negative X-ray required) NEGATIVE ☐

CHEST X-RAY POSITIVE ☐ (If positive, report of negative X-ray required) NEGATIVE ☐

OD OS — VISION WITHOUT GLASSES | OD OS — VISION WITH GLASSES | RIGHT LEFT — HEARING

*Does the student have any scars or identifying marks?* ☐ YES ☐ NO

*If yes, please describe:* ______

*Has the student ever had any of the following:*

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | **Allergies to medications** | ☐ | ☐ | **Chicken Pox** |
| ☐ | ☐ | **Other allergies** | ☐ | ☐ | **Rheumatic Fever** |
| ☐ | ☐ | **Asthma** | ☐ | ☐ | **Rubella** |
| ☐ | ☐ | **Appendicitis Chronic** | ☐ | ☐ | **Scarlet Fever** |
| ☐ | ☐ | **Cough (recurring)** | ☐ | ☐ | **Hepatitis** |
| ☐ | ☐ | **Diabetes Mellitus** | ☐ | ☐ | **Hernia** |
| ☐ | ☐ | **Enuresis** | ☐ | ☐ | **Malaria** |
| ☐ | ☐ | **Thyroid (goiter, struma)** | ☐ | ☐ | **Seizure Disorder** |
| ☐ | ☐ | **Parasites** | ☐ | ☐ | **Sleepwalking** |
| ☐ | ☐ | **Vertigo, dizziness** | ☐ | ☐ | **Eating Disorder** |
| ☐ | ☐ | **Headache (persistent, recurring)** | ☐ | ☐ | **Learning or Speech Defect** |

*Any disease, impairment, or abnormality of:*

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Bones, Joints, Locomotor System** |
| ☐ | ☐ | **Throat or Nose** |
| ☐ | ☐ | **Blood, Endocrine System** |
| ☐ | ☐ | **Nervous System** |
| ☐ | ☐ | **Ears or Hearing** |
| ☐ | ☐ | **Eyes or Vision** |
| ☐ | ☐ | **Genito-Urinary System** |
| ☐ | ☐ | **Cardiovascular System** |
| ☐ | ☐ | **Respiratory System** |
| ☐ | ☐ | **Skin (Acne, etc.)** |
| ☐ | ☐ | **Abdominal Organs, Digestive System** |

*If "yes" was checked for any of the above, the physician must provide full details:*

______

*Has the student ever been hospitalized?* ☐ YES ☐ NO

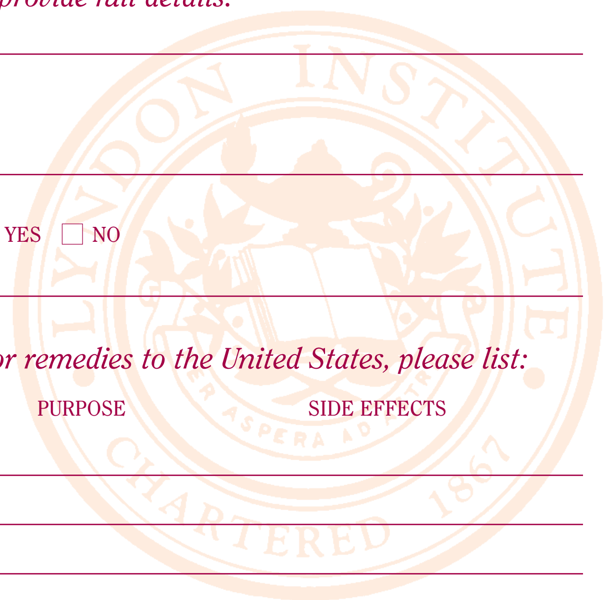
*If yes, please explain:* ______

*Is student currently taking any medications or injections?* ☐ YES ☐ NO

*If yes, please explain:* ______

*If the student will bring any medications, prescriptive drugs, or remedies to the United States, please list:*

| MEDICATION | DOSAGE/FREQUENCY | PURPOSE | SIDE EFFECTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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## IMMUNIZATION RECORD

*Vermont state law requires that all students must be adequately immunized before entering school:* **Tetanus** *must have been given within the past 10 years;* **Polio** *series must be complete;* **MMR** *must have 2 shots;* **Hepatitis B** *must have 3 shots;* **Varicella** *must have 2 shots; and* **Meningococcal** *must have 1 shot. Please provide the date each immunization dose was given (day/month/year).*

| VACCINE | 1ST | 2ND | 3RD | 4TH | 5TH |
|---|---|---|---|---|---|
| **DPT** (Diphtheria, Pertussis, Tetanus) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR |
| **TdaP** (Tetanus, Diphtheria, Acellular, Pertussis) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | | | |
| | / / DAY/MONTH/YEAR | | | | |
| *Either* **OPV** (Oral Polio) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | |
| *or* **IPV** (Inactivated Polio Virus) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | |
| **MMR** (Measles, Mumps, Rubella) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | | | |
| **Hepatitis B** (Or Lab Report of Positive Titer) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | | |
| **Varicella** (Or Lab Report of Positive Titer) | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | | | |
| **Menningitis** (Menactra or MCV4) | / / DAY/MONTH/YEAR | | | | |
| **Other** | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR | / / DAY/MONTH/YEAR |

*Has the student ever consulted a neurologist, psychologist, or specialist in nervous or emotional disorders?*

☐ YES ☐ NO *If yes, please explain:* ____________________

*Can the student participate in daily physical education classes and extracurricular sports?* ☐ YES ☐ NO

*Are there any restrictions on the student's participation in physical education and/or sports?* ☐ YES ☐ NO

*If yes, please describe:* ____________________

*What is your opinion of the student's physical and mental health?* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

*Please detail any disease, impairment, or abnormality not fully explained on either side of this form:*

____________________

____________________

I, the undersigned, have reviewed the medical history of this student and have given him/her a thorough physical examination. I certify that all important medical information has been noted on this form and that nothing relevant has been omitted.

____________________ ____________________
PHYSICIAN'S SIGNATURE PHYSICIAN'S NAME (PRINT)

____________________ ____________________
ADDRESS DATE OF EXAMINATION

Lyndon INSTITUTE

# Medical Information and Parental Permission Form for Athletes

*Signature on this form indicates that the student-athlete and parent(s) or guardian(s) agree to abide by the athletic policies of the Vermont Principals' Association and Lyndon Institute.*

## ATHLETE INFORMATION

ATHLETE'S FIRST NAME MIDDLE INITIAL LAST NAME

ADDRESS

CITY STATE OR PROVINCE ZIP COUNTRY

DATE OF BIRTH (MONTH/DAY/YEAR) SOCIAL SECURITY NUMBER

SPORT(S)

BROKEN BONE(S) - DATE(S)

RECENT HEAD INJURY- DATE

LAST TETANUS SHOT - DATE

INSURANCE COMPANY POLICY NUMBER

*Do you want Tylenol as needed?* ☐ YES ☐ NO

*Do you have any physical problems or restrictions?* ☐ YES ☐ NO

*If yes, please describe:* ____________________

*Are you currently taking any medications?* ☐ YES ☐ NO

*If yes, what are they?* ____________________

*Do you have any allergies?* ☐ YES ☐ NO

*If yes, what are they?* ____________________

I am aware that playing or practicing in any sport can be dangerous in nature involving MANY RISKS OR INJURY - major and minor. Because of the dangers of participating in sports, I recognize the importance of following coach's instruction regarding playing techniques, training, and other team rules and agree to obey such instructions.

ATHLETE NAME SIGNATURE DATE

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# Medical Information and Parental Permission Form for Athletes

## FOR PARENT OR GUARDIAN

PARENT/GUARDIAN NAME

HOME PHONE WORK PHONE

### Liability Release

I am aware that playing or practicing in any sport can be dangerous in nature involving MANY RISKS OR INJURY - major and minor. Because of the dangers of participating in sports, I recognize the importance of following coach's instruction regarding playing techniques, training, and other team rules and agree to obey such instructions.

### Permission for Treatment

In case of injury acquired during interscholastic competition, athletic practice, or physical education on school grounds or during a school-sponsored activity, I hereby consent to have the above named student examined and, if required, to be treated by a physician or hospital. I am of the understanding that, in case of injury, Lyndon Institute will make every effort to contact me prior to taking the student to a physician or hospital. In the event I cannot be notified, Lyndon Institute and its representative has my permission to take appropriate steps to insure the safety and well-being of my child.

,

I, the parent/guardian of ______________________________
ATHLETE NAME

have read, understand, and agree with the Liability Release and Permission for Treatment statements above. I give Lyndon Institute and authorized personnel permission to sign for treatment in case of accident or injury.

PARENT (OR LEGAL GUARDIAN) NAME SIGNATURE DATE

## PHYSICIAN'S STATEMENT

This is to certify that ______________________________
ATHLETE NAME

was examined by me and is physically able to compete in athletics. ☐ YES ☐ NO

PHYSICIAN'S NAME SIGNATURE DATE