ST JOHNSBURY ACADEMY

2016 RESIDENT LIFE and HEALTH FORMS

ST. JOHNSBURY, VERMONT

QUESTIONS?

CONTACT
FORMS@STJACADEMY.ORG
802-751-2130

DUE JULY 1

HEALTH AND RESIDENT LIFE FORMS

Email to forms@stjacademy.org or upload to your SNAP Health Portal page. Login information will be sent directly to parents and consultants.

Included on the following pages are important forms from the Campus Life, Health, and Business Offices that need to be returned by **JULY 1, 2016.**

Before returning these forms, please take a few moments and be sure you have signed and dated all the appropriate areas.

WE HAVE PREPARED THESE FORMS AS PDFS FOR YOUR CONVENIENCE. SIMPLY FILL OUT THE INFORMATION AND EMAIL THE FILES BACK TO US!

If at any point during this process you have questions please call the appropriate department (Campus Life Office, Business Services Office, Nurse's Office). We will be happy to answer any questions you might have.

If you wish to fax the required forms, the Admission Office fax number is 802-748-5463.

IMPORTANT NUMBERS

Admission Office

Jan Monteith
EXECUTIVE ASSISTANT
802-751-2313
jmonteith@stjacademy.org

Admission Office fax: 802-748-5463

Campus Life Office

Buffie Hegarty
ADMINISTRATIVE ASSISTANT
802-751-2307
bhegarty@stjacademy.org

Campus Life Office Fax: 802-748-7712

Business Services Office

Marci McGinn
STUDENT ACCOUNTS COORDINATOR
802-748-7705
mmcginn@stjacademy.org

Business Office Fax 802-751-2127

Nurse's Office

Crystal Prevost
ADMINISTRATIVE ASSISTANT
802-748-7717
cprevost@stjacademy.org

Nurse's Office Fax 802-748-7798

ST. JOHNSBURY ACADEMY

1000 Main Street, St. Johnsbury, Vermont 05819
Telephone: (802) 751-2130, **Fax:** (802) 748-5463
www.stjohnsburyacademy.org

Resident Life Forms must be returned by July 1.

STUDENT INFORMATION

PLEASE PRINT FULL NAME BELOW (REQUIRED FOR ALL FORMS)

STUDENT LAST NAME

STUDENT FIRST NAME

STUDENT MIDDLE NAME

STUDENT NICKNAME

DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____ GENDER: ☐ MALE ☐ FEMALE

STUDENT E-MAIL ADDRESS

( ) **STUDENT** CELL PHONE WITH AREA CODE

COUNTRY

NATIONALITY

CITIZENSHIP

Student Guardian Information

With whom does the student reside: ☐ Mother ☐ Father ☐ Guardian

MOTHER/GUARDIAN LAST NAME

MOTHER/GUARDIAN FIRST NAME

MOTHER/GUARDIAN MAILING ADDRESS: STREET

STREET LINE 2

CITY STATE COUNTRY ZIP CODE

( ) **MOTHER/GUARDIAN** HOME PHONE WITH AREA CODE

( ) **MOTHER/GUARDIAN** WORK PHONE WITH AREA CODE

MOTHER/GUARDIAN E-MAIL ADDRESS

( ) **MOTHER/GUARDIAN** CELL PHONE WITH AREA CODE

( ) **MOTHER/GUARDIAN** FAX NUMBER WITH AREA CODE

FATHER/GUARDIAN LAST NAME

FATHER/GUARDIAN FIRST NAME

FATHER/GUARDIAN MAILING ADDRESS: STREET

STREET LINE 2

CITY STATE COUNTRY ZIP CODE

( ) **FATHER/GUARDIAN** HOME PHONE WITH AREA CODE

( ) **FATHER/GUARDIAN** WORK PHONE WITH AREA CODE

FATHER/GUARDIAN E-MAIL ADDRESS

( ) **FATHER/GUARDIAN** CELL PHONE WITH AREA CODE

( ) **FATHER/GUARDIAN** FAX NUMBER WITH AREA CODE

Please print full **STUDENT NAME** below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME

STUDENT FIRST NAME

Consultant Information (if applicable)

CONSULTANT COMPANY NAME

CONSULTANT LAST NAME

CONSULTANT FIRST NAME

CONSULTANT MAILING ADDRESS: STREET

STREET LINE 2

CITY STATE COUNTRY ZIP CODE

( )

CONSULTANT WORK PHONE WITH AREA CODE

( )

CONSULTANT CELL PHONE WITH AREA CODE

( )

CONSULTANT FAX NUMBER WITH AREA CODE

CONSULTANT E-MAIL ADDRESS

Emergency Contact

In case of emergency, please give the name and phone number of the person to be contacted.

EMERGENCY CONTACT LAST NAME

EMERGENCY CONTACT FIRST NAME

RELATIONSHIP TO STUDENT

( )

EMERGENCY CONTACT HOME PHONE WITH AREA CODE

( )

EMERGENCY CONTACT WORK PHONE WITH AREA CODE

( )

EMERGENCY CONTACT FAX NUMBER WITH AREA CODE

EMERGENCY CONTACT E-MAIL ADDRESS

PARENTAL PERMISSION FORM

Because of the responsibility and liability involved, it is necessary for the Academy to forbid resident students to ride in cars without the written permission of the parent. The permission, if granted by the parent, must be on file in the dormitory master's office before the student will be permitted to use private transportation while under the jurisdiction of the school. This form grants permission to ride in any vehicle not owned by the Academy. **The school does not encourage such permission.** Transportation to Academy functions will, of course, be provided. St. Johnsbury Academy reserves the right to withhold the privilege provided by the above permission if the situation warrants.

My child ☐ has, ☐ does not have, my permission to ride in private cars with an adult

My child ☐ has, ☐ does not have, my permission to ride in private cars with a student driver

X

PARENT/GUARDIAN SIGNATURE DATE

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME

STUDENT FIRST NAME

PERMISSION TO PHOTOGRAPH

St. Johnsbury Academy uses photographs of students in their marketing materials.

PLEASE INDICATE WHETHER OR NOT YOU GRANT PERMISSION FOR USE OF YOUR CHILD'S PHOTO.

☐ Yes, I give my permission for St. Johnsbury Academy to use my child's photo for school-related activities.

☐ No, I do not give my permission for St. Johnsbury Academy to use my child's photo for school-related activities.

X _____

PARENT/GUARDIAN SIGNATURE DATE

STUDENT ACTIVITY FORM

All resident students are required to participate in extracurricular or intramural programs, unless there is a physical handicap. We encourage students to become active in sports or other physical activities.

I GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN ACADEMY ACTIVITIES WITH THE FOLLOWING EXCEPTIONS:

1. _____
2. _____
3. _____
4. _____

X _____

PARENT/GUARDIAN SIGNATURE DATE

COMMUNICATION

St. Johnsbury Academy provides consistent communication to parents regarding the daily activities of life on campus via the Academy's website **www.stjvacademy.org.** We utilize e-mail as the primary communications vehicle to send announcements, school closing, travel plans, etc.

A valid e-mail address is vital to our efforts to communicate effectively.

Please provide the primary e-mail address(es) that the Academy should use for these important communications:

_____

STUDENT NAME

_____

PRIMARY E-MAIL ADDRESS

_____

SECONDARY E-MAIL ADDRESS

IF YOUR CONTACT INFORMATION CHANGES, PLEASE E-MAIL CHANGES TO JAN MONTEITH AT JMONTEITH@STJACADEMY.ORG

ST. JOHNSBURY ACADEMY
1000 Main Street, St. Johnsbury, Vermont 05819
Telephone: (802) 751-2130, **Fax:** (802) 748-5463
www.stjohnsburyacademy.org

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME **STUDENT** FIRST NAME

PERMISSION FOR MEDICAL TREATMENT / RELEASE OF MEDICAL INFORMATION (To be completed every year)

In rare instances, a surgical emergency arises in which written consent by the parent or guardian is legally required but the proper person cannot be located. In this event, and in order to avoid delay which might jeopardize the life or recovery of a student, we request the following information from the parents or guardian, with the understanding that every effort will be made to contact them in an emergency.

Student's Social Security Number: _____

I authorize the School Nurse, or other health care providers considered appropriate by them, to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment, or counseling for my (son, daughter, ward). I authorize the School Nurse or other physicians or surgeons considered appropriate by him/her to give necessary anesthesia and perform emergency surgical operations on my (son, daughter, ward).

I agree to notify St. Johnsbury Academy of any conditions arising when my (son, daughter, ward) is not at school.

I hereby authorize St. Johnsbury Academy to release information concerning my child to appropriate health care providers.

I authorize health care providers to release information to the school.

I hereby authorize payment directly to the health care provider of the hospital insurance benefits otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the health care provider for charges not covered by this authorization and any applicable rates and terms.

Our health care professionals, counselors, advisors, and administrators strive to respect the privacy of our students; however, there are times when information may need to be shared with parents, select faculty, and school officials. Therefore, parents and students consent, as a condition of enrollment, that otherwise confidential health care and counseling information may be disclosed on a need to know basis to the extent necessary to protect the health, safety, and welfare of the student and community.

X _____
PARENT/GUARDIAN SIGNATURE DATE

Please print full **STUDENT NAME** below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME

STUDENT FIRST NAME

HEALTH INSURANCE INFORMATION (To be completed every year)

Every student MUST HAVE health insurance

PLEASE INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD AND PRESCRIPTION DRUG CARD.

POLICY HOLDER'S NAME DOB

POLICY NUMBER

POLICY HOLDER'S SOCIAL SECURITY NUMBER

GROUP NUMBER

RELATIONSHIP TO POLICY SUBSCRIBER

INSURANCE COMPANY NAME

WHERE TO SEND CLAIM FORMS MAILING ADDRESS:

STREET

STREET LINE 2

CITY

STATE

COUNTRY

ZIP CODE

( )

TELEPHONE NUMBER WITH AREA CODE

PERSON RESPONSIBLE FOR HEALTH CARE BILLS

LAST NAME

FIRST NAME

( )

HOME PHONE WITH AREA CODE

( )

BUSINESS PHONE WITH AREA CODE

( )

FAX NUMBER WITH AREA CODE

E-MAIL ADDRESS

MAILING ADDRESS:

STREET

STREET LINE 2

CITY

STATE

COUNTRY

ZIP CODE

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME

STUDENT FIRST NAME

To be completed by Parents every year

The following over the counter medications will be administered to your child on an as needed basis. Please indicate below any objections or allergies we may need to be aware of.

MEDICATION

Tylenol
Ibuprofen
Sudafed (cold medicine)
Antacid
Benadryl
Cough suppressants
Anti-Diarrhea
Laxative
Other
Medication prescribed by the Physician

OBJECTIONS/ALLERGIES _____

CONSENT TO DRUG TEST / RELEASE OF MEDICAL INFORMATION

I/we understand that our student may receive disciplinary action, including suspension and/or expulsion from St. Johnsbury Academy, for violating the Academy's Substance abuse policy. Therefore, I/we hereby give consent for said student's urine and/or blood to be obtained for drug/alcohol testing. I also give permission for Northeastern Vermont Regional Hospital to release aforementioned test results to the Headmaster of St. Johnsbury Academy and shall hold said hospital and healthcare providers at said hospital harmless and release them from any liability in performing said test and release of the results.

X _____
STUDENT SIGNATURE DATE

_____
PRINTED NAME OF STUDENT

X _____
PARENT/GUARDIAN SIGNATURE DATE

_____
PRINTED NAME OF PARENT/GUARDIAN

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME **STUDENT** FIRST NAME

MEDICAL HISTORY (To be completed by Parents every year)

Does your child have or ever had?	YES	NO	Comment
ADHD /Learning Disability			
Alcohol/Substance use			
Anemia/Blood disorder			
Asthma/Lung problems			
Back problems			
Cancer/Tumor			
Chest pain/Shortness of breath			
COUNSELING/PSYCHOTHERAPY			Doctor's Name Phone number
Dental problems			
Depression			
Diabetes			
Ear, Nose, Throat problems			
Eye problems			
Fainting/Loss of consciousness			
Fractures/Sprain/Dislocation			
Headaches			
Head injury/Concussion			
Heart Disease			
High Blood Pressure			
Intestinal/Digestive problems			
Kidney disease/Bladder			
Measles			
Mononucleosis			
Mumps			
Pneumonia			
Rheumatic Fever			
Seizures			
Significant Anxiety			
Sinusitis			
Skin problems			
Special Diet			
TB			
Thyroid/Hormone problems			
Tobacco Use			
Weight change/Anorexia			
ALLERGIES:			Reaction:
			Date of last Dental exam / /

REPORT OF HEALTH EVALUATION (To be completed by a Physician every year)

Year of graduation_____

TO THE EXAMINING PHYSICIAN: PLEASE REVIEW THE STUDENT'S HISTORY AND COMPLETE THIS PHYSICAL FORM. PLEASE COMMENT ON ALL "YES" ANSWERS.

_____ _____ _____ _____ SEX: ☐ F ☐ M

STUDENT LAST NAME | **STUDENT** FIRST NAME | DATE OF BIRTH | YEAR OF GRADUATION

Blood pressure _____

Weight _____ Height _____

Tuberculin Skin Test: **ALL STUDENTS** from Latin America, the Caribbean, Africa, Asia, Eastern Europe and Russia

Date _____ Type _____ BCG Date _____

Result: ☐ Negative ☐ Positive Induration _____ mm

Has the student had Chest x-ray? result _____ 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? _____

Allergies _____

ARE THERE ABNORMALITIES OF THE FOLLOWING SYSTEMS? DESCRIBE FULLY. PLEASE 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

(If 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 _____

X _____

SIGNATURE OF **DOCTOR/PHYSICIAN** DATE

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME **STUDENT** FIRST NAME

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.

I confirm do not confirm that the above named Student is capable of self-administration of his/her medication when traveling from home to school or to school-related destination or when traveling to his/her destination during school vacations and when signing off from campus on weekends. Towards that end, I further confirm that the Student has been advised of the possible side-effects of all prescription medications, including any possible interactions with the above-listed over-the-counter medications and supplements, and has been informed of when and how to access emergency services.

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

X SIGNATURE OF **DOCTOR/PHYSICIAN** DATE

Please print full **STUDENT NAME** below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME **STUDENT** FIRST NAME

IMMUNIZATIONS (To be completed the first year at St. Johnsbury Academy)

This information is required and very important.

Prior to your student entering St. Johnsbury Academy, he/she must have completed the Vermont state required immunizations listed below. All students who do not have proof of the requires immunizations will be immunized locally at the family's expense, which could be as much as $500, depending on the immunization required.

DIPHTHERIA/PERTUSSIS/TETANUS

MONTH DAY YEAR

Date of dose 1 ____/____/____
Date of dose 2 ____/____/____
Date of dose 3 ____/____/____
Date of dose 4 ____/____/____
Date of dose 5 ____/____/____
TDAP ____/____/____

TDAP must have regardless of last TD date

POLIO

MONTH DAY YEAR

Date of dose 1 ____/____/____ ☐ OPV ☐ IPV
Date of dose 2 ____/____/____ ☐ OPV ☐ IPV
Date of dose 3 ____/____/____ ☐ OPV ☐ IPV
Date of dose 4 ____/____/____ ☐ OPV ☐ IPV

HPV VACCINE: (HIGHLY RECOMMENDED)

Check the appropriate box: ☐ Gardasil ☐ Other

Date of dose 1 MONTH/DAY/YEAR
Date of dose 2 ____/____/____
Date of dose 3 ____/____/____

MEASLES/MUMPS/RUBELLA (MMR)

Date of dose 1 MONTH/DAY/YEAR
Date of dose 2 ____/____/____

TUBERCULIN TEST - Students from Latin America, Caribbean, Africa, Asia, Eastern Europe, Russia

TB skin test Date: MONTH/DAY/YEAR
Results_____ mm in duration
(positive over 10mm in duration)
If **Positive skin test**: Date of chest x-ray: MONTH/DAY/YEAR
Results: _____
Previous BCG Date: MONTH/DAY/YEAR

HEPATITIS B

MONTH DAY YEAR

Date of dose 1 ____/____/____
Date of dose 2 ____/____/____
Date of dose 3 ____/____/____

MENINGOCOCCAL VACCINE (REQUIRED BY VT LAW)

Check the appropriate box: ☐ Menomune ☐ Menactra
Date of dose 1 MONTH/DAY/YEAR

VARICELLA (REQUIRED IF NO HISTORY OF DISEASE)

Date of dose 1 MONTH/DAY/YEAR
Date of dose 2 ____/____/____
History of disease Date: ____/____/____

Permission for Influenza Vaccine: HIGHLY RECOMMENDED

Please check one:

☐ Has my permission to receive the influenza vaccine
☐ Does **NOT** have my permission to receive the influenza vaccine

By Law, students may not be enrolled in school without this information

I AUTHORIZE ST. JOHNSBURY ACADEMY TO COMPLETE THE NECESSARY SERIES OF IMMUNIZATIONS.

X _____
PARENT/GUARDIAN SIGNATURE DATE

REQUIRED FOR STUDENTS TAKING PRESCRIPTIONS OR SUPPLEMENTS ONLY

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT'S LAST NAME **STUDENT'S** FIRST NAME

PARENTAL CONSENT AND AGREEMENT (To be completed every year)

I _____, acknowledge and agree that all prescriptions and over-the-counter medications/supplements must be given to the St. Johnsbury Academy Director of Health and Wellness, together with written orders from a physician. (The physician's orders must detail the name of the drug, dosage, time interval the medication is to be taken, diagnosis, and reason for giving.) My completion of this form constitutes my request for The Academy to comply with the physician's orders. I hereby assure St. Johnsbury Academy that my child has suffered no previous ill effects from the use of the listed medications.

My completion of this form constitutes my request and consent to have SJA store and administer, and allow my child to self administer, the listed prescription and non-prescription medications and supplements. I specifically consent to St. Johnsbury Academy: (1) to store and administer the listed medications, over-the-counter medications and supplements to my child, (2) to disclose these medications whenever it seeks medical services on my child's behalf, and (3) to have my son/daughter self-administer the listed medications as indicated by his/her physician's attached orders and the information listed in this form.

I give further permission to St. Johnsbury Academy for my son/daughter to have in his/her possession their prescribed medications when traveling from home to school or to school-related destination or when traveling to his/her destination during school vacations and when signing off from campus on weekends. I agree that my child will be given only the amount of prescription medications (except for the listed emergency medications) needed for the time he/she will be away from school.

I acknowledge and agree that medication must be brought to school in a container labeled by the pharmacy or physician and stored by the St. Johnsbury Academy Director of Health Services, or his or her designee, in a secure storage place.

I acknowledge and agree that I have reviewed the possible side effects of the listed non-prescription medications and supplements (listed on the medication or supplement's container) with my child.

I acknowledge and agree that I have disclosed all information concerning any life threatening allergies or asthma that my child may have to the St. Johnsbury Academy Director of Health and Wellness and hereby agree to supplement that information as needed in order to ensure my child's safety and well being. Students with life threatening allergies or with asthma, and whose parents or guardians have completed the consent form below, shall be permitted to possess and self-administer emergency medication at school, on school grounds, at school-sponsored activities, on school-provided transportation, and during school-related programs.

I further agree to provide St. Johnsbury Academy a newly completed form (accessed from the School's website) whenever my child's prescription and non-prescription medications are changed. I agree to telephone the St. Johnsbury Academy Director of Health Services with any specific new instructions related to medications and to e-mail or fax the newly completed form promptly to:

Sarah Garey, RN, NCSN, CADC
Director of Health Services
802-748-7718 | fax 802-748-7798
sgarey@stjacademy.org

I further acknowledge and agree that if I have any concerns or questions about the administration of my child's medication or supplements, then I will contact without delay the St. Johnsbury Academy's Director of Health Services.

I hereby release the school, its employees and agents, including volunteers, from liability as a result of any injury arising from my child's self-administration of the above-listed prescription, non-prescription medications, or supplements.

X _____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

REQUIRED FOR STUDENTS TAKING EMERGENCY MEDICATIONS ONLY

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT'S LAST NAME **STUDENT'S** FIRST NAME

PARENTAL AUTHORIZATION FORM - EMERGENCY MEDICATION

(To be completed every year)

As the parent (or guardian) of _____, I hereby authorize my child to possess and self administer emergency medication at school, on school grounds, at school sponsored activities, on school provided transportation, and during school-related programs.

As documented by the attached physician's statement, my child has _____ (name the specific life-threatening allergies or asthma applicable to this authorization), and is capable of, and has been instructed by the physician in, properly self-administering the emergency medication named by the physician.

As further documented by the attached physician's statement, my child has been advised of possible side-effects of the medication and has been informed of when and how to access emergency services.

The attached plan of action, developed specifically for the 2016/2016 school year, in consultation with the SJA Director of Health Services, is based on the documentation provided by the physician's statement and includes the name of each emergency medication, the dosage, and the times and circumstances under which the medication is to be taken. The plan of action also indicates that the medication is solely for the use of my child, and includes the names of individuals who will be given copies of the plan. I understand that one of the requirements of the plan is that my child will notify a school employee or agent after self-administering emergency medication.

I hereby release the school, its employees and agents, including volunteers, from liability as a result of any injury arising from my child's self-administration of emergency medication.

X _____

SIGNATURE OF PARENT/GUARDIAN DATE

SCHOOLMED

Pre-packaged Medications for Students

REQUIRED FOR STUDENTS TAKING PRESCRIPTION MEDICATIONS ONLY

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 prescribed on an 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 – 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 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.

Please print full STUDENT NAME below (required for all forms)

Resident Life Forms must be returned by July 1.

STUDENT LAST NAME

STUDENT FIRST NAME

POCKET MONEY/ALLOWANCE ACCOUNTS (OPTIONAL)

As a convenience to families, parents may choose to deposit funds in to a pocket money/allowance account held for safekeeping by the Business Office. Funds are distributed to students either as weekly "pocket money" or on an as needed basis for student expenses such as weekend activities, shopping and entertainment.

To open a Pocket Money account you may send funds via bank wire, credit card, electronic check (ACH)) or by mailing a check.
Credit card deposits may be made online at www.stjacademy.org
Choose Online Payments from the Quicklinks menu, then Credit card/ACH Payments.

Electronic check (ACH) payments may be made online by U.S. families at www.stjacademy.org
Choose Online Payments from the Quicklinks menu, then Credit card/ACH Payments.

Bank wire instructions:

Wire to: TD Bank, N.A., 301 Railroad Street, St. Johnsbury, VT 05819, (802) 748-3185
Swift Code: NRTHUS33XXX
ABA#: 0311-0126-6
Credit to: St. Johnsbury Academy, 1000 Main Street, St. Johnsbury, VT 05819
Account Number: 94190881
Memo: *Student's Name*

Weekly Pocket Money Authorization:

○ **I LIMIT THE AMOUNT OF MY STUDENT'S POCKET MONEY TO $ _____ PER WEEK.**
Any fund requests above this amount will require written permission via email to mmcginn@stjacademy.org.
Requests for$400 or more over the limit must be approved by either Mr. Ryan or Mr. Robillard.

○ **I ALLOW MY STUDENT TO WITHDRAW FUNDS ON A WEEKLY BASIS AS NEEDED WITH NO RESTRICTIONS.**

X _____ STUDENT SIGNATURE _____ DATE

X _____ PARENT/GUARDIAN SIGNATURE _____ DATE

FOR MORE INFORMATION, PLEASE E-MAIL MARCI MCGGIN AT MMCGINN@STJACADEMY.ORG

BUSINESS OFFICE FORM

ST. JOHNSBURY ACADEMY

1000 Main Street, St. Johnsbury, Vermont 05819
Telephone: (802) 751-2130, **Fax:** (802) 748-5463
www.stjohnsburyacademy.org

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