



North Carolina Department of Health and Human Services  
Office of Education Services

**The Governor Morehead School for the Blind**  
2303 Mail Service Center • Raleigh, North Carolina 27699-2303  
301 Ashe Avenue • Administration Building • Raleigh, NC 27606

Bev Perdue, *Governor*  
Lanier M. Cansler, *Secretary*

Dwight Pearson, Ph.D, Ed. S., *OES Superintendent*  
Barbria Bacon, *GMS Director*

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Dear Parent/Guardian,

The Governor Morehead School Student Health Services is looking forward to your child attending the short-term session/summer camp program this year. In order to assure that the best possible medical services are provided for your child you will need to have the attached forms completed.

If your child needs medications administered to him/her, a written physician's order must be on file in the student health center. This includes, but is not limited to vitamins, herbal preparations, food supplements, ointments, acne preparations, and artificial tears. Medications are kept in the student health center and administered according to physician instructions by the nurses. No medications are allowed in the cottages. Do not place any medications in your student's bag, pocket, or suitcase. Medications and other medical information should be handed directly to the bus monitor or the nurse on duty. All medications must come in the original container with the pharmacy labeling. **Please DO NOT write on the label.** We do not accept medications sent in expired containers. The student health center cannot administer medications if these requirements are not met. **There will be no exceptions and your child may be sent home.** Please send us enough medication to last for the entire program. Keep some in reserve for your use when your child goes home. No medications will be sent back and forth on days of departure, usually Fridays, with the exception of a few medications (i.e. oral contraceptives, antibiotics).

Enrollment to *each* short-term session/summer camp is contingent on medical clearance from the student health center. All forms must be submitted before May 19, 2009. **You will receive a phone call from GMS staff verifying that your child is medically cleared and on the roster to attend the upcoming short-term session/ summer camp program.**

If you have any questions, please feel free to contact me at 919-715-0817 or the Student Health Center at 919-733-9787.

Sincerely yours,  
Health Center

**A TB SKIN TEST IS REQUIRED OF ALL SHORT-TERM/ SUMMER CAMP STUDENTS PRIOR TO ATTENDANCE AT GMS. THESE RESULTS MUST BE CURRENT WITHIN TWELVE MONTHS OF SHORT-TERM SESSION OR SUMMER CAMP DATE. YOUR PHYSICIAN CAN DOCUMENT THE RESULTS ON THE ENCLOSED PHYSICAL EXAMINATION FORM.**

Physical Examination Form Short-Term 2009-10

This form is to be completed by a licensed physician, physician's assistant or nurse practitioner.

Student Name: _____	Birthdate: ____/____/____	Date of Physical: ____/____/____
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**VITAL SIGNS/LABS/ALLERGIES:**

HT:	WT:	Temp:	Pulse:	Resp:	BP:	HGB/HCT:
U/A:	Protein:	Glucose:	Blood:	Sp. Gravity:	PH:	Leukocytes:

**PHYSICAL EXAMINATION:**

**\*\*TB MANTOUX TYPE SKIN TEST (required): Date Placed:** \_\_\_\_\_

**\*\*Results-(record in mm):** \_\_\_\_\_ **Date Read:** \_\_\_\_\_

Check if Normal:	Describe Abnormalities:
<input type="checkbox"/> Eyes	
<input type="checkbox"/> Ears/Nose/Throat	
<input type="checkbox"/> Head/Neck	
<input type="checkbox"/> Chest/Heart/Lungs	
<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Genitalia/Hernia/Testes (Boys)	
<input type="checkbox"/> Menses/Breast Exam (Girls if age appropriate)	
<input type="checkbox"/> Skin	
<input type="checkbox"/> Extremities	
<input type="checkbox"/> Spine	
<input type="checkbox"/> Neurological	

Please summarize history or findings and/or elaborate on above if necessary:

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN RESTRICTIONS:** Students are required to participate in curriculum required physical education and are expected to meet athletic team responsibilities and commitments unless restricted by written physician order.

**Physical Activity:** Please list specific restriction and duration of restriction:

\_\_\_\_\_

\_\_\_\_\_

**Special Dietary Restriction:** Please list specific diet. A written physician's order is required for dietary supplements, MVI and non-traditional diets. Start and stop dates and follow up dates for reassessment must be provided

\_\_\_\_\_

\_\_\_\_\_

I hereby certify that I have examined the student herein described and have reviewed this student's health history. I certify that this student is able to participate in all academic, athletic and residential activities except as noted above.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**\*\* TB is required of all short-term/ summer camp students prior to attendance at GMS, (tests must be current within twelve months of short-term session date)**

**THIS FORM IS TO BE COMPLETED BY THE PHYSICIAN, BEFORE YOU CAN COME to GMS Short-Term sessions. The physical exam and current medication orders MUST accompany this form.**

Student Name: \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

**IN CASE OF EMERGENCY Name:** \_\_\_\_\_  
 Relationship to student \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insurance: \_\_\_\_\_  
 Hospitalization Yes \_\_\_\_ No \_\_\_\_ with whom: \_\_\_\_\_ **(Please provide insurance card)**  
 Policy # \_\_\_\_\_  
 Accident Yes \_\_\_\_ No \_\_\_\_ with whom: \_\_\_\_\_  
 Policy # \_\_\_\_\_

**THIS PORTION TO BE COMPLETED BY PHYSICIAN**

Physician's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 List any serious illness the student may have had in the last three months \_\_\_\_\_

Has the student had surgery in the last three months? Yes \_\_\_\_ No \_\_\_\_  
 If yes explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check **Yes** or **No** and **explain any problems that were checked yes or that the student may have:**

	Yes	No		Yes	No
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems (constipation/diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Resistance	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	VP shunt	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Close contact with a party infected with Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Traveled outside the U.S in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Mobility problems	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems/ Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	To what? _____	Reaction _____	

Cause of visual impairment: \_\_\_\_\_  
 Secondary diagnosis \_\_\_\_\_

**Give details on the student health including any limitations/athletic limits, and current medications. Please describe any medical, surgical, or any mental health care hospitalizations that have occurred within the past 6 months**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Student Health Center**

**Medication Authorization Form (Rev May 08)**

**This portion to be completed by physician**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please write each medication name, strength (ex: 100 mg), dose (how many pills to be given), the route (by mouth, apply to skin, rectally), and the times the medication is to be given while at home. Please use back for additional medications.

**Name of Medication                      Strength                      Dose                      Route                      Time to be given**


**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician's Name(print): \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**This portion to be completed by parent/guardian**

I, as the parent/legal guardian of the above named student, do hereby give permission for my child to receive the following medication(s) regularly as prescribed by a licensed physician. I understand that:

- Medication is to be administered by GMS nursing staff or designated personnel, when prepared by the pharmacy/nursing staff
- The medication purpose, potential side effects/adverse reactions, and any precautions or special directions regarding medication administration, have been explained to me by my child's physician, nursing staff, pharmacist, counselor, or medication information sheet
- As the parent, I may(at any time), revoke permission to have the medication(s) administered

This permission is valid for the school year 2009-2010 \_\_\_\_\_

I have read and understand the above information \_\_\_\_\_

**Office of Educational Services  
Medical Permission Form  
2009-2010 School Year**

As the parents/guardian of \_\_\_\_\_, a student at Governor Morehead School, I do hereby authorize GMS to act as my representative in giving consent for acute/emergency medical, dental, ophthalmology and/or optometry treatment as well as any psychiatric/psychological counseling necessary, during the school year. In case of an emergency, prior to any major medical treatment, every effort will be made to contact me. As parent/guardian, I will assume responsibility for all expenses involved in the treatment of my child not covered by the school or other insurance. I assume responsibility for expenses incurred related to purchasing prescription medication for my child. GMS will not be financially responsible for providing prescription medication to students. I will provide a valid insurance card to GMS to be used for my student to obtain acute/emergency medical services and/or medication.

I authorize the release of any health care information from any health care facility or physician to the school physician or the school nurse. I authorize the release of any and all health care information from the school physician or the school nurse, which in their best judgment is necessary for the health and well being of my student.

I authorize the Student Health Center staff and school physician to:

- Provide acute and routine health care services to my student.
- Provide vision, health and dental screenings as required or recommended by the Department of Public Instruction and NCDHHS.
- Administer medications and treatments for my student as directed by the Student Health Center Physician.
- Transport my student to health care facilities such as Wake Med Hospital and Wake Radiology.
- Radiology for acute/emergency services deemed necessary by the school physician.
- Accept physician orders for medication, treatment regimens, and dosage adjustments to said physician order and I understand that if discrepancies exist between my dosage request and the written physician's order that the nurse is obligated to administer medication as written on the physician's order until a new order is obtained which concurs with my dosage request.

I agree to:

- Provide physician's orders signed by the prescribing physician, and all medications, treatments, special dietary order/restrictions, alternative medication and therapy.
- Provide all medication in pharmacy labeled containers listing the name of the medication or treatment, the name of the prescribing physician, current dosage schedule, the date of the prescription and the number of refills.
- Provide update emergency contact information to the nursing staff immediately when such information changes.
- Be financially responsible for payment of all health care bills generated in health care facilities and pharmacies other than those stock health care supplies and the services provided by the nursing staff and school physician within the confines of the Student Health Center.

I understand that:

- My student is required to participate in curriculum required physical education.
- The NC High School Athletic Association requires my student to have sports physical within the previous 12 months before being allowed to practice or play in any interscholastic team sport.
- This authorization shall be effective upon the first day of school and shall end upon the last day of school.

Your child's confidential medical/psychiatric record will be maintained at the Student Health Center. The Student Health Center staff may use or disclose your child's information to any referred physician, clinic, or hospital in order to provide, coordinate or manage his/her medical/psychiatric care. This information may include allergies, medical problems (current and past), and psychiatric history summary, current information (i.e. behavior/ treatment plan), medications history and regimens. This information may be provided to appropriate staff members working directly with my child on a one to one 'need to know' basis and only minimal information needed to assist with providing my child appropriate care will be released. Information to be shared with other staff would include allergies, potential side effects of medications and care for medical conditions, physical disabilities and limitations, psychiatric history summary, current treatment plan and behavior plan so as to assure appropriate care is provided to my child.

Signature of Parent/Guardian \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

## **Consent for Medication Administration**

### **By Non-Medical Personnel 2009-2010**

Designated non-medical school personnel will be trained annually to administer medication to students when a nurse is unavailable. Medications given by non-medical personnel will include prescription medications and non-prescription medication on field trips and weekend activities. No medications will be given without prior authorization from Student Health Center nursing staff. Approval for medication will be given for the symptoms a student presents. The medication given will be included in the standing orders that are signed by our staff physician. A student may request to come to the Student Health Center at any time.

#### **Over-the-Counter Medications given by Non-Medical Personnel**

Maalox  
Ibuprofen or Tylenol  
Cepacol throat lozenges

I hereby authorize Student Health Center staff to delegate administration of prescription and over-the-counter medications and prescription medications for field trips to my child by non-medical personnel.

Parent Signature \_\_\_\_\_

I do not authorize Student Health Center staff to delegate administration of over-the-counter medications by non-medical personnel. I do however authorize non-medical personnel to administer to my child prescription and over-the-counter medications while my child is on a school sponsored field trip. I understand that my child will have to come to the Student Health Center for all medications while on campus.

Parent Signature \_\_\_\_\_

**THE GOVERNOR MOREHEAD SCHOOL  
DIET REQUISITION**

TODAY'S DATE: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_

D.O.B. \_\_\_\_\_

GENERAL DIET ORDER: (PLEASE CIRCLE APPROPRIATE CHOICES)

<b>CONSISTENCY</b>	<b>TOTAL CALORIES</b>	<b>SPECIAL NEEDS</b>
REGULAR	3200 - 3600	DIABETIC
PROGRESSIVE CHOPPED	2200 - 2400	REDUCED CALORIE
CHOPPED	1800	LOW SODIUM (NO ADDED SALT)
GROUND	1500	LOW CHOLESTEROL / LOW FAT
PUREED	1200	OTHER: _____
	OTHER: _____	

MEDICAL COMMENTS /  
NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE USE THIS AREA TO DETAIL MEAL PLANS, SNACKS OR ADAPTIVE EQUIPMENT  
NEEDS

SIGNATURE of Physician or Parent: \_\_\_\_\_ DATE \_\_\_\_\_