MERCY HIGH SCHOOL

Dear New Mercy Family,

For the upcoming school year, we will be shifting all student medical information to an online database. **Please have your doctors fill out the attached forms, and then upload them online**. The management system we have adopted is called Magnus Health SMR (Student Medical Record). As this is a web-based system, you will have continuous access to your child's health record as well as the ability to make updates when needed. You will also have the option to access the account after your child graduates.

On **July 6, 2022**you will have access to your Magnus Health SMR account. You will receive an email from service@magnushealthportal.com to create your password! You will have two weeks to access your account **before the link will expire-** please keep an eye out for this email! We ask that you enter the health information required within your Magnus Health SMR account for each child attending Mercy no later than **July 23, 2022.**

To access your Magnus Health Account:

On July 6 you will receive an email from service@magnushealthportal.com inviting you to create your password for your account. You will log into https://secure.magnushealthportal.com/ with your username/password to access your child(ren)'s Magnus Health account(s).

Questions or Problems?

If you are having difficulty navigating the Magnus system, entering data online, or downloading the hardcopy coversheets and forms, or if you have any other questions, please contact customer support at Magnus Health SMR by phone at (919) 502-7689 or by email at service@magnushealthportal.com.

Thank you so much for your patience and for your participation as we launch this program this year. **Please plan to complete Magnus forms for each enrolled child by July 23.**

Sincerely,

Mary Rizzi-Ayd RN, BSN
School Nurse

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MERCY HIGH SCHOOL — BALTIMORE —

PHYSICAL EXAMINATION FORM

(To be completed and signed by Physician / Nurse Practitioner / Physician Assistant)

Name: _____ DOB: _____ Age: _____ Examination Date: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Temp: _____

Vision: _____ WNL _____ Glasses _____ Contacts Were immunizations given today? _____ No _____ Yes

Has the student tested positive for COVID-19? _____ No _____ Yes Date of diagnosis? _____

Has the student been vaccinated for COVID-19? _____ No _____ Yes Date of vaccinations: Dose 1 _____ Dose 2 _____

Vaccine name? _____

If immunizations were given today, OR student is new to the school, please attach an updated immunization record.

PE FINDINGS

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Mobility	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Musculoskeletal/Orthopedic	☐	☐	☐
Cardiac/Murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Endocrine	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
ENT	☐	☐	☐	Psychosocial	☐	☐	☐
GI	☐	☐	☐	Respiratory	☐	☐	☐
GU	☐	☐	☐	Skin	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	☐

REMARKS: *(Please explain any abnormal findings.)*

_____

Allergies: _____

List of any Medications: _____

_____

Does the student have a health condition, which may require **EMERGENCY ACTION** or **ongoing monitoring while at school?**
_____ Yes _____ No

Explain: _____

_____

_____

The student named at the top of this form has been _____ **CLEARED OR** _____ **NOT CLEARED** to participate in all physical activities/sports at Mercy High School without restrictions.

If **not** cleared for **all** physical activity without restrictions, the specified activities which I recommend she **DOES NOT** participate in are:

_____

_____ / Date: _____ _____

SIGNATURE OF MEDICAL EXAMINER MD, NP, PA Name, Address & Phone of Examiner (print/stamp)

MERCY HIGH SCHOOL — BALTIMORE —

A NEW FORM IS NEEDED EACH SCHOOL YEAR

OVER-THE-COUNTER PERMISSION/AUTHORIZATION FORM

The Over-the-Counter Medication Permission/Authorization Form is to be completed, signed and returned to Mercy High School by the first day of orientation. Part I is to be completed (check yes or no) and signed by a parent/guardian. Part II is to be completed and signed by your daughter's physician. No medications of any type will be given to your daughter until this form, Part I and Part II, is completed and on file in the Health Office. It is school policy and state law that no student may carry or take any medications unless under the supervision of the school nurse/school administrators.

PART I: Parent Consent for Administration of Over-the-Counter Medication

Student's Name _____ Year of Graduation _____

Known Allergies _____

Medications Taken Regularly _____

Check the over-the-counter medications listed below that you wish to be available to your daughter in school.

1.	Acetaminophen (generic Tylenol)	Yes ____	No ____		5.	Neosporin bacitracin ointment	Yes ____	No ____	
2.	Ibuprofen (generic Advil)	Yes ____	No ____		6.	Hydrocortisone cream .5-1%	Yes ____	No ____	
3.	Antacid (generic Tums)	Yes ____	No ____		7.	Benadryl	Yes ____	No ____	
4.	Cough Drops	Yes ____	No ____						

I give permission for my daughter to receive the above medications that I have checked during school hours to be administered by the school nurse.

_____ _____

Parent/Guardian Please PRINT Clearly Parent/Guardian Signature

---

Part II: Physician Authorization Form for Over-the-Counter Medications

Student's Name _____

1.	Acetaminophen (325 mg) 1-2 tabs po q4hr pm (for headache, fever, mild muscle discomfort, menstrual cramps)	Yes _____	No _____
2.	Ibuprofen (200 mg) 1-2 tabs q4-6 hr prn (for headache, mild to moderate muscle discomfort, menstrual cramps)	Yes _____	No _____
3.	Antacid (Tums) 1-2 tabs po (for mild to moderate gastric hyperacidity)	Yes _____	No _____
4.	Cough drops 1-2 po prn (for mild throat irritation or cough)	Yes _____	No _____
5.	Bacitracin/Neosporin ointment topical (for minor cuts, skin abrasions)	Yes _____	No _____
6.	Hydrocortisone cream 0.5-1% topical (for insect bites, mild rashes)	Yes _____	No _____
7.	Benadryl 25 mg to 50 mg po q4-6 hrs prn (for allergic reactions)	Yes _____	No _____

_____ _____

Physician's Signature Date

*Stamp physician name, address
and phone number here.

Revised 5/2021

Mercy High School
School Medication Administration Authorization Form

This order is valid only for school year (current) _____ including the summer session.

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify:

_____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Self Carry/Self Administration of Emergency Medication Authorization/Approval

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____ _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____ _____
Signature Date

Order reviewed by the school RN: _____ _____
Signature Date

Revised 5/2021