2024 | Boarding Life and Health Forms

St Johnsbury Academy

THE SJA EXPERIENCE

QUESTIONS?

CONTACT
FORMS@STJACADEMY.ORG
802-751-2130

DUE JULY 1

BOARDING LIFE AND HEALTH 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, 2024.**

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 FILLABLE 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

Ann Bissonnette
ADMINISTRATIVE ASSISTANT
IMMIGRATION COORDINATOR
802-751-2411
ann.bissonnette@stjacademy.org

Robin Legendre
ADMINISTRATIVE ASSISTANT
802-751-2364
robin.legendre@stjacademy.org

Admission Office fax: 802-748-5463

Campus Life Office

Laurie Lang
EXECUTIVE ASSISTANT
802-751-2307
laurie.lang@stjacademy.org

Campus Life Office Fax: 802-748-7712

Business Services Office

Stacie Ruggles
EXECUTIVE ASSISTANT
802-748-7708
stacie.ruggles@stjacademy.org

Business Office Fax 802-751-2127

Nurse's Office

Sarah Garey
DIRECTOR OF HEALTH SERVICES
802-748-7718
sarah.garey@stjacademy.org

Jill Cahoon
ADMINISTRATIVE ASSISTANT
802-748-7717
jill.cahoon@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
stjacademy.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

PREFERRED NAME

DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

GENDER: _____ SEX: _____ PRONOUNS: _____

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) **RETURN 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) **RETURN 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.stjacademy.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 ADMISSIONS@STJACADEMY.ORG

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

Please print full STUDENT NAME below (required for all forms) **RETURN 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 (for U.S. citizens): _____

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

Choosing Health
NORTHEASTERN VERMONT REGIONAL HOSPITAL

HIPAA Directive- Designation of Personal Representatives

I _____, permit the staff at Northeastern Vermont Regional Hospital to discuss my Protected Health Information in person or by telephone with the person(s) named below for purposes of communicating results, findings, and care decisions. This includes the ability to make, cancel, or reschedule appointments on my behalf, assist me in making payments, and inquiring about my billing account. Such individuals shall be considered my personal representative(s) as defined in 45 CFR Section 164.502 of the regulation adopted under the Health and Insurance Portability Act of 1996.

Name	Relationship	Contact Number
Sarah Garey	Nurse	802-274-0321
Alison Willard	Nurse	802-274-0674
Simona Ponoran	Nurse	908-821-6665

I understand and acknowledge that the protected health information I am authorizing Northeastern Vermont Regional Hospital to share with my personal representative(s) may contain sensitive information relating to drug/alcohol diagnosis and treatment, mental health care and treatment, reproductive health, sexually transmitted diseases, and HIV/Aids information.

I understand and acknowledge that this designation applies to all clinical areas and practices of Northeastern Vermont Regional Hospital.

This authorization shall remain in effect for the duration of one year from the date of signature. I understand that I may cancel the designation at any time by filling out and signing a HIPAA Disclosure Revocation form. I further understand that any cancellation will only apply to future disclosures of actions regarding my personal health information and cannot cancel actions or disclosures made while the designation was in effect. Submitting a new HIPAA Directive form will revoke any existing HIPAA Directive forms that were previously in place.

_____ _____
Patient's Name Printed Date and Time:

_____ _____
Signature of Patient or Legal Representative Legal Representatives' Name (if applicable)

_____ _____
Witness Name Printed Date and Time:

_____
Signature of Witness

Choosing Health
NORTHEASTERN VERMONT REGIONAL HOSPITAL

GENERAL CONSENT FORM

Consent for Treatment:

I voluntarily consent to care and treatment by Northeastern Vermont Regional Hospital. Treatment includes but is not limited to physical and mental examination, diagnostic tests, medical procedures, medications, testing for HIV, by the medial staff, employees, other trainees, and authorized agents of Northeastern Vermont Regional Hospital as may be considered necessary or advisable in their professional judgement. I understand that I have the right to make informed decisions regarding my care and treatments, as this right includes the right to refuse any treatments that I do not want. I know that no guarantees have been made to me about the results of the care provided.

Telemedicine

I further agree and give my consent to participate in a telemedicine health service, including telemedicine services provided by Dartmouth-Hitchcock providers, if recommended for my care and treatment. I understand there are limitations to the technology and the process of telemedicine, including the potential for incomplete exchange or loss of information, interruptions, and technical difficulties. I understand that the medical records of my telemedicine health services provided by Dartmouth-Hitchcock providers will be maintained by *NVRH, but* may also be stored in the Dartmouth-Hitchcock electronic medical record.

Patients' Bill of Rights and Patient Responsibilities:

I have been offered a copy of the Patients' Bill of Rights and Patient Responsibilities and recognize that I can be offered assistance with any questions**.**

Personal Belongings:

I release Northeastern Vermont Regional Hospital from all responsibility of my personal belongings. I also release Northeastern Vermont Regional Hospital from loss or damage to articles including but not limited to jewelry and clothing which must be removed to carry out a procedure and for articles not claimed from safekeeping after 30 days of discharge.

Assignment of Benefits:

In consideration for the services rendered or to be rendered, I hereby irrevocably assign and transfer to Northeastern Vermont all rights, title and interest, to the benefits payable by any and all third party payers (including Medicare and Medicaid) that are available or may be liable for the services rendered to the patient. If I am eligible for any Medicare or Medicaid benefits, I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is true and correct. I understand the Hospital has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payers, and I am responsible for payment for any charges not paid for me on my behalf.

Financial Responsibility:

Even if I have insurance, I may be responsible for charges for my care that others do not pay on my behalf. I will pay Northeastern Vermont Regional Hospital any unpaid charges. If the matter is sent to a collection agency or an attorney for collection, I will pay the outstanding charges and all lawyer's fees and collection expenses.

I have read and understand the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. I certify that I accept the terms and conditions; or, is the patient or legal guardian of the patent, or is otherwise duly authorized as the Patient's agent to execute this consent form accept its terms.

Print Name:	Patient Signature or Authorized Representative*	Time and Date

Witness Name:	Witness Signature:	Time and Date

Please print full STUDENT NAME below (required for all forms) **RETURN BY JULY 1**

STUDENT LAST NAME **STUDENT** FIRST NAME

HEALTH INSURANCE INFORMATION (To be completed every year)

Every student MUST HAVE health insurance

International Students

International students will be signed up for health insurance through St. Johnsbury Academy if insurance information is not provided. This program costs approximately $2500.

HEALTH INSURANCE COMPANY | GROUP NUMBER | PARTICIPANT ID NUMBER

NAME OF SUBSCRIBER | PHARMACY ID NUMBER (IF APPLICABLE)

U.S. Students

All U.S. students boarding at St. Johnsbury Academy must have health insurance that can be used in Vermont.

HEALTH INSURANCE COMPANY | GROUP NUMBER | PARTICIPANT ID NUMBER

NAME OF SUBSCRIBER | PHARMACY ID NUMBER (IF APPLICABLE)

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 include a copy of both sides of your insurance card and drug prescription card.

Please print full STUDENT NAME below (required for all forms) **RETURN 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
Cold Medicine
Antacid
Benadryl
Cough suppressants
Anti-Diarrhea
Laxative
Other

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) **RETURN BY JULY I**

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/Vape			
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: **Please see pages 16-18.**

Date _____ Type _____ BCG Date _____

Result: ☐ Negative ☐ Positive Induration _____ mm

If skin test is positive, has the student had chest x-ray? Result _____ Date_____

Please include copy of chest x-ray report (only necessary with positive Tuberculin Skin Test).

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.

DIPHTHERIA/PERTUSSIS/TETANUS

Date of dose 1 MONTH/DAY/YEAR
Date of dose 2 _____/_____/_____
Date of dose 3 _____/_____/_____
Date of dose 4 _____/_____/_____
Date of dose 5 _____/_____/_____
TDAP _____/_____/_____

POLIO

Date of dose 1 MONTH/DAY/YEAR ☐ OPV ☐ IPV
Date of dose 2 _____/_____/_____ ☐ OPV ☐ IPV
Date of dose 3 _____/_____/_____ ☐ OPV ☐ IPV
Date of dose 4 _____/_____/_____ ☐ OPV ☐ IPV

(Dose 4 must be after age 4)

HPV VACCINE: (HIGHLY RECOMMENDED)

Date of dose 2 MONTH/DAY/YEAR
Date of dose 3 _____/_____/_____

MEASLES/MUMPS/RUBELLA (MMR)

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

Permission for Influenza Vaccine: HIGHLY RECOMMENDED

☐ Has my permission to receive the influenza vaccine

TUBERCULIN TEST - Please see form on pages 14-16

HEPATITIS B

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

VARICELLA (REQUIRED IF NO HISTORY OF DISEASE)

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

COVID-19

☐ Moderna ☐ pfizer Other _____
Date of dose 1 MONTH/DAY/YEAR
Date of dose 2 _____/_____/_____
Date of booster _____/_____/_____

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

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.

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

X _____
PARENT/GUARDIAN SIGNATURE DATE

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please write the name of the country, below _____) ❑ Yes ❑ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, [St. Johnsbury Academy] requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes** ☐ **No** ☐

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes** ☐ **No** ☐

---

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes ☐ **No** ☐

If No, proceed to 2 or 3

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive ☐ negative ☐

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive ☐ negative ☐

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight. .

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT ☐ T-Spot ☐ other_____
M D Y

Result: negative ☐ positive ☐ indeterminate ☐ borderline ☐ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT ☐ T-Spot ☐ other_____
M D Y

Result: negative ☐ positive ☐ indeterminate ☐ borderline ☐ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal ☐ abnormal ☐
M D Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

☐ Student agrees to receive treatment

☐ Student declines treatment at this time

_____ _____
Health Care Professional Signature Date

St. Johnsbury Academy Health Services
1000 Main Street
St. Johnsbury, Vermont 05819
(802) 748-7718

Prepared originally by ACHA's Tuberculosis Guidelines Task Force
Revised by Emerging Public Health Threats and Emergency Response Coalition

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
sarah.garey@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 2024/2025 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

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

STUDENT LAST NAME | **STUDENT** FIRST NAME | **STUDENT** NICK NAME

(OPTIONAL) POCKET MONEY/ALLOWANCE ACCOUNTS

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

Any request for $400.00 or more must be approved by either Mr. Ryan or Mr. Robillard.

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 by choosing Online Payments from the Quicklinks menu, selecting Make an Online Payment, then Make a Payment, and following online instructions.
- Electronic check (ACH) payments may be made by U.S. families only. Make payments online at www.stjacademy.org by choosing Online Payments from the Quicklinks menu, selecting Make an Online Payment, then Make a Payment, and following online instructions. The ACH (electronic check) option is available below the credit card choices listed in small type.
- Bank wire instructions:
  Wire to: TD Bank, N.A., 301 Railroad Street, St. Johnsbury, VT 05819, (802) 748-3185
  Swift Code: NRTHUS33XXX
  Credit to: St. Johnsbury Academy, 1000 Main Street, St. Johnsbury, VT 05819
  Account Number: 5243090412
  Memo: *Student's Name*

Weekly Pocket Money Authorization (please select one):

☐ **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 sjapocketmoney@stjacademy.org.

☐ **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 CHRIS VALLEY AT CHRIS.VALLEY@STJACADEMY.ORG

BUSINESS OFFICE FORM

ST. JOHNSBURY ACADEMY

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

PLEASE RETURN THESE FORMS BY JULY 1.

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

THANK YOU AND WE LOOK FORWARD TO SEEING YOU IN AUGUST!

CHARACTER | INQUIRY | COMMUNITY

1000 Main Street
St. Johnsbury, Vermont 05819
Admissions (802) 751-2130 **Fax** (802) 748-5463
admissions@stjacademy.org
stjacademy.org