The Oxbow School Medical History and Wellness Information Forms
(*To be completed by a parent/guardian)*

Oxbow Student First, Middle, and Last Name:

Date of Birth:

Gender:

Parent/Guardian First and Last Name:

Date:

Cell Number:

Email:

Please review and fill out the following:

GENERAL HEALTH QUESTIONNAIRE: Parent(s)/Guardian(s) must fill out this form in order for their child to participate in the Oxbow semester. Please note that for any questions marked "Y" that have a *CALL notation, an Oxbow representative will contact you if necessary to discuss the student's needs.

ALLERGY and/or DIETARY RESTRICTIONS: This form must be completed if a student has any known allergies or medical dietary restrictions. Please include a food allergy and anaphylaxis emergency plan (FARE) signed by your physician.

MEDICATIONS: This form must be completed if a student will be taking medications while attending Oxbow. This includes prescriptions, over-the-counter medications, daily supplements, herbal remedies, and any other medications the student will be bringing to Oxbow.

ADD/ADHD or Learning Disorder: This form must be completed if a student has a current diagnosis of Attention Deficit Disorder (ADD) and/or Attention Deficit and Hyperactivity Disorder (ADHD) or a learning disorder (LD).

MENTAL HEALTH: This form must be completed if a student has a past or current history of mental illness.

ORTHOPEDIC: This form must be completed if a student has an unresolved or ongoing orthopedic injury.

Students must have a physical completed within 12 months of the start of their Oxbow semester.

The Oxbow School Medical History and Wellness Information Form

(*To be completed by a parent/guardian)*

Please read the items in each column and carefully respond to each item (Y, N or N/A) regarding any past or current medical issues or concerns regarding the condition/problem/illness listed. Include current, chronic, and episodic condition(s). **For each "YES" item from the right hand column above, please attach a separate sheet fully explaining the history, current status, and note the treating physician's name and phone number.**

Please select Yes or No to each item in this column:
ALLERGY and/or DIETARY RESTRICTIONS ☐ Yes ☐ No Bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies. Medical dietary restrictions. If "Yes," complete the ALLERGY/DIETARY RESTRICTIONS form.
MEDICATIONS ☐ Yes ☐ No Prescription medications, over-the counter medications, dietary supplements, herbal remedies, and any other medications. If "Yes," complete the MEDICATIONS form.
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER ☐ Yes ☐ No Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and other related issues or learning disorders. If "Yes," complete the ADD/ADHD form.
MENTAL HEALTH ISSUES/ILLNESS ☐ Yes ☐ No Anxiety disorders, depression, past history of suicide attempt or ideation, past addiction to alcohol or drugs, self-abuse, or any other mental health issues. If "Yes," complete the MENTAL HEALTH form.
ORTHOPEDIC INJURIES ☐ Yes ☐ No Shoulder, arm, elbow, hand, neck, back, hips, leg, knee, ankle, foot, recurrent strains of particular muscles, recurrent sprains of particular joints, hernia, other musculoskeletal issues, and other athletic or orthopedic injuries. If "Yes," complete the ORTHOPEDIC form.
Complete and accurate information is crucial to our ability to appropriately support students.

Please select Yes, No or N/A for this column:	Y	N	N/A
Addiction or regular use of alcohol or drugs ***CALL**			
Altitude: Acute Mountain Sickness (AMS)			
High Altitude Cerebral Edema (HACE) ***CALL**			
High Altitude Pulmonary Edema (HAPE) ***CALL**			
Asperger's, autism, or PDD			
Bleeding, blood disorders, tuberculosis, hepatitis			
Cancer			
Cardiovascular (heart and vessels) abnormalities or problems, including high blood pressure			
Circulatory problems			
Cold injuries			
Dental problems			
Diabetes ***CALL**			
Ear, eye, nose & throat infections/issues			
Eating disorder			
Epilepsy or seizure disorders ***CALL**			
Fainting or dizziness, chronic ***CALL**			
Gastrointestinal tract			
Head injuries, concussions, headaches			
Heat injuries			
Hormonal and/or thyroid dysfunction ***CALL**			
Hypertension			
Kidney or liver disease/issues			
Menstrual cramps			
Neurological disorders			
Pregnancy, current ***CALL**			
Reproductive tract			
Respiratory tract, including asthma			
Skin problems			
Sleepwalking			
Sudden death under age 50 of family member ***CALL**			
Syncope with exertion (fainting during exercise) ***CALL**			
Tobacco regular use and/or addiction ***CALL**			
Urinary tract			
Vision or hearing issues or impairment			
Other, including hospitalization in last 5 years (explain):			

The Oxbow School
ALLERGY/DIETARY RESTRICTIONS Related Medical History and Information Form
(*To be completed by a parent/guardian)*

Student Full Name:

On the Medical History and Wellness Information Form, you listed that the student has allergies (i.e. bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies) and/or dietary restrictions. When we have the proper information, we can accommodate many allergies. Please complete the questionnaire below.

Allergy/Allergen:
When diagnosed with this allergy:
How diagnosed with this allergen:
Symptoms during an allergic reaction (what happens?):
During a reaction: face swelling and/or difficulty breathing (anaphylactic reaction)? ❒ Yes ❒ No
Does the student take any medication for this allergy? ❒ Yes ❒ No (If yes, be sure to complete the medications information form.)
Has the student ever been hospitalized for this particular allergy? ❒ Yes ❒ No (If yes, explain in detail on separate sheets as necessary.)
Is the student on an allergy desensitization program? ❒ Yes ❒ No (If yes, will this require treatment while at Oxbow? Please explain in detail.)
Does the student have and carry epinephrine for this allergy? ❒ Yes ❒ No (If yes, the student must bring **two** delivery devices to Oxbow.)
Additional Information:

Allergy/Allergen:
When diagnosed with this allergy:
How diagnosed with this allergen:
Symptoms during an allergic reaction (what happens?):
During a reaction: face swelling and/or difficulty breathing (anaphylactic reaction)? ❒ Yes ❒ No
Does the student take any medication for this allergy? ❒ Yes ❒ No (If yes, be sure to complete the medications information form.)
Has the student ever been hospitalized for this particular allergy? ❒ Yes ❒ No (If yes, explain in detail on separate sheets as necessary.)
Is the student on an allergy desensitization program? ❒ Yes ❒ No (If yes, will this require treatment while at Oxbow? Please explain in detail.)
Does the student have and carry epinephrine for this allergy? ❒ Yes ❒ No (If yes, the student must bring **two** delivery devices to Oxbow.)
Additional Information:

DIETARY RESTRICTIONS:
To assist us in planning expeditions and meals, please describe any medical restrictions. (Have your physician or allergist complete the food allergy & anaphylaxis emergency care plan (FARE).

The Oxbow School
MEDICATIONS Related Medical History and Information Form
(*To be completed by a parent/guardian)*

Student Full Name:

In consultation with your family physician, please complete the following questionnaire regarding the student's medications. If the student is taking more than one medication, please complete a separate form for each medication (copy this form as necessary).

Medication Brand Name:
Medication Generic/Chemical Name:
Reason for taking this medication:
Start Date using this medication: End Date (if known):
Regular Dose:
Frequency and Time of Dose(s):
Triggers (signs and symptoms) for dosing, if applicable (e.g. onset of shortness of breath):
This medication should be taken: ❒ With food ❒With water ❒On an empty stomach Other:
Common side effects:
Uncommon side effects:
Harmful interactions (i.e. 'doesn't work with ibuprofen'):
Indications or contraindications for use regarding: intensive sun exposure, altitude (5-14,000 ft.), rigorous exercise, cold exposure, heat exposure?
Missed dose procedure: ❒Skip dose ❒Take immediately ❒Double dose at next scheduled time ❒Call physician ❒ Other:
Symptoms if the student misses a dose?
Prescribing Physician's Name: Phone number:
Will the student come to Oxbow with sufficient supplies for the duration of their program? ❒ Yes ❒ No If no, please elaborate on the plan to refill the prescription:
Are there any medications that the student is currently taking that they will not be taking during the Oxbow program? If so, please describe, noting the reason for the medication termination.
Additional information:

The Oxbow School
ADD/ADHD or Learning Disorders Related Medical History & Information Form
(*To be completed by a parent/guardian)*

Student Full Name:

Does the student have: ❒ Attention Deficit Disorder (ADD) ❒ Attention Deficit Hyperactivity Disorder (ADHD) ❒Both
When was the ADD and/or ADHD diagnosed:
What behaviors led to the diagnosis:
During the last two years, has the student taken any medications for ADD/ADHD? ❒ Yes ❒ No
Is the student taking any medications for ADD/ADHD? ❒ Yes ❒ No (If yes, be sure to complete the medications information form.)
What happens if the student misses a dose?
Under the current treatment, how does the student's ADD/ADHD manifest itself?
Does the ADD/ADHD interfere with school or work? If so, how?
What, if any, are the prescribed accommodations for academic school work? Homework? Testing? Please attach additional sheets if necessary.
Treating Counselor/Therapist/Physician's Name:
Treating Counselor/Therapist/Physician's Phone:
Additional Information: (please attached additional sheets if necessary)

The Oxbow School
Mental Health Related Medical History & Information Form
(*To be completed by a parent/guardian)*

Student Full Name:

Does the Oxbow student have: ❒Depression ❒ Anxiety Disorder ❒ Addiction ❒ Suicide Attempt or Suicidal Ideation ❒ Cutting or other Self Abuse ❒ Other (explain):
When did symptoms first occur:
When was the above diagnosed:
What were the symptoms and/or behaviors:
Has the student seen a counselor or therapist in the last two years?
Is the student currently seeing a counselor or therapist?
Counselor/Therapist Name: Phone Number:
Under current treatment, how does the student's mental health issue manifest itself?
Does the mental health issue interfere with school and/or social interactions? If so, how?
Has the student ever had suicidal ideations or attempted suicide? ❒ Yes ❒ No (If yes, when?)
During the last two years, has the student taken any medications for mental health issues? ❒ Yes ❒ No
Is the student currently taking any medications for mental health issues? ❒ Yes ❒ No (If yes, please complete the medications information form.)
Making new friends and learning to function in a group can be stressful. With that in mind: What triggers stress for the student?
What can we do at Oxbow to help minimize stressful situations which may arise during the program?
Has the student ever been hospitalized for psychiatric illness? ❒ Yes ❒ No (If yes, please explain when, for how long, and why. Be specific.)
Additional Information:

The Oxbow School
Orthopedic Related Medical History & Information Form
(*To be completed by a parent/guardian)*

Student Full Name:

Injury:	When:
How was the injury treated?	
Did the student have physical therapy? ❒ Yes ❒ No (If yes, for how long and when?)	
Does the student still have pain as a result of this injury? ❒ Yes ❒ No (If yes, what causes the pain and for how long?)	
Does the student still have loss of function or disability as a result of this injury? ❒ Yes ❒ No (If yes, describe the disability, be specific.)	
Which description best describes the student's current condition? ❒ No longer a concern ❒ Stable ❒ Improving ❒ Worsening	
Since this injury, has the student played sports, carried a backpack, run, or hiked for regular intervals? Be specific.	
Is the student currently taking any medications for the above injury? ❒ Yes ❒ No (If yes, please complete the medications information form.)	
Do you anticipate the student being limited in their ability to participate in physically demanding activities? ❒ Yes ❒ No (If yes, for what activities, and for how long?)	
Injury:	When:
How was the injury treated?	
Did the student have physical therapy? ❒ Yes ❒ No (If yes, for how long and when?)	
Does the student still have pain as a result of this injury? ❒ Yes ❒ No (If yes, what causes the pain and for how long?)	
Does the student still have loss of function or disability as a result of this injury? ❒ Yes ❒ No (If yes, describe the disability, be specific.)	
Which description best describes the student's current condition? ❒ No longer a concern ❒ Stable ❒ Improving ❒ Worsening	
Since this injury, has the student played sports, carried a backpack, run, or hiked for regular intervals? Be specific.	
Is the student currently taking any medications for the above injury? ❒ Yes ❒ No (If yes, please complete the medications information form.)	
Do you anticipate the student being limited in their ability to participate in a physically demanding program? ❒ Yes ❒ No (If yes, for what activities, and for how long?)	

If the injury occurred recently (within the last 6 months) or is persistent, please have the treating physician acknowledge that participation in an Oxbow program will not cause further damage or harm and note this on the Annual Physical Exam form.

The Oxbow School
Special Information
(*To be completed by a parent/guardian)*

Student Full Name:

Testing and/or Learning Differences Information

Do you have an individualized education plan (IEP) or documented learning difference? ❒ Yes ❒ No If "yes", please explain in detail and attach related documentation.
Are you allowed extra time for the SAT or AP exams by the College Board? ❒ Yes ❒ No
Are you allowed extra time for the ACT? ❒ Yes ❒ No
Are you allowed extra time at your sending school for tests? ❒ Yes ❒ No
If you have special test taking requirements, we need documentation before you arrive. Your parents and/or your school should have the necessary paperwork. For standardized tests, we need a copy of a letter from The College Board or ACT that includes your personal SSD Code. Please send copies directly to: admissions@oxbowschool.org
Have you sent any test taking documentation to Oxbow? ❒ Yes ❒ No, I will email it by_____ ❒ NA – not applicable