The Wellness Center
Forms and Information

You and your parents need to read the attached information carefully, and complete all necessary forms. (These required forms are also available on our website under the Wellness Center - Forms and Waivers). Massachusetts state law requires that the Wellness Center have your completed insurance and health information forms (including completed Massachusetts immunization forms) on file before you can move into the residence halls and attend classes.

Please complete and return the following forms as soon as possible and no later than July 15th for students entering in the fall and January 1st for students entering in the spring.

To be completed by a physician:

- Physical Examination
- Immunization Records
- EpiPen form (if applicable).

Immunizations required for college students in Massachusetts may differ from your state of residency. If you are missing any of the required immunizations, you need to receive them prior to your arrival on campus. If your physician does not have your complete immunization record, please obtain records from your current school and/or previous provider.

To be completed by the student and their family:

With the exception of the Physical Examination and Immunization records, all forms should be completed by you and your family. Be thorough in completing all forms—the information you submit is necessary for us to care for you if you become ill on campus, and to support your ongoing health and well-being.

Please feel free to contact the Wellness Center directly if you have any questions at 413-528-7353 or wellnesscenter@simons-rock.edu or visit The Wellness Center on the college’s website.

Please return the completed forms to:

The Wellness Center
Bard Academy/Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 413-528-7353 F: 413-528-7358
wellnesscenter@simons-rock.edu
The following pages need to be filled out by the student and a parent or guardian (if the student is a minor) with the exception of the physical exam and the immunization records pages. **If there are any changes to this information during the academic year, please notify the Wellness Center.**

**STUDENT IDENTIFICATION**

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**NOTIFY IN EMERGENCY (Parent/Guardian)**

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Confidential Sharing Agreement and Consent for Treatment

Bard College at Simon’s Rock assures that medical information will be regarded as confidential and shared only as necessary for the student’s immediate safety or as allowed by law. **Minor students (under 18 yrs.) cannot remain on campus** until Health Services receives a signed Consent for Treatment form.

I hereby give my permission for the medical and counseling staff of the Wellness Center at Bard Academy and Bard College at Simon’s Rock, and their off-site medical providers, to provide and share medical and counseling information as needed and appropriate for the medical/counseling treatment of my child during the time they are enrolled as a student at Bard Academy or Bard College at Simon’s Rock. Furthermore, I give my permission to Bard Academy and/or Bard College at Simon’s Rock to arrange for/ or provide transportation for my child to receive medical treatment. In case of an emergency, I give my permission for transportation and treatment of my child at a medical facility which may include: ambulance transport, medical treatment, psychiatric evaluation and/or treatment, and when necessary, hospitalization. I also understand counseling services are available for all enrolled college and academy students, and I give permission for my child to utilize counseling services while enrolled.

Signature of Parent/Guardian *(required if student is under 18 years of age)* Date

MEDICALALERT/MEDICATIONALLERGIES

Insurance Information
All students are required to purchase the Academy/College health insurance. **Family insurance will be used as necessary.**

Bard Academy/Bard College at Simon’s Rock
Health Insurance
Consolidated Health Plans,
195 Stafford Street,
Springfield, MA 01104
413-733-4540

Do you have health insurance coverage under a family or individual policy? □ yes □ no

IF YES, PLEASE ATTACH A COPY OF YOUR HEALTH INSURANCE CARD

Please attach a copy of the FRONT of your insurance card here

Please attach a copy of the BACK of your insurance card here

SUBSCRIBER’S NAME: ___________________________ D.O.B. ___________________

INSURANCE COMPANY: ___________________________ INSURANCE ID# ___________________
PHYSICAL EXAM RECORD

Simon’s Rock requires from your medical provider a record of a physical exam within the last 12 months. Please have your history reviewed by your health care provider and have them fill out the information below. State regulation mandates that Health Services be in possession of relevant health records before a student assumes residency at the College. Include copies of any other records you feel pertinent.

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<td>Blood Pressure</td>
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<td>Medication Allergies</td>
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<td>ACTIVE medical/psychiatric issues:</td>
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<td>Significant PAST medical/psychiatric issues:</td>
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<td>Current Medications:</td>
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This individual has been prescriber an EpiPen: ☐ YES ☐ NO

*If yes, EpiPen form must be completed and returned*

Please check if normal and explain otherwise.

<table>
<thead>
<tr>
<th>HEENT</th>
<th>Lungs</th>
<th>Spine (Scoliosis)</th>
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<tr>
<td>Neck</td>
<td>Skin</td>
<td>Neuro</td>
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<td>Cardiac</td>
<td>Extremities</td>
<td>Abdomen</td>
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Healthcare Provider Signature: ____________________________ Print Name: ____________________________

(must be non-family member)

Address: ______________________________________________________________________________________

Phone: ____________________________ Fax: ____________________________
**MASSACHUSETTS REQUIRED IMMUNIZATION HISTORY**

This form must be signed by a physician. The state of Massachusetts mandates receipt of health records **BEFORE** students reside on campus. Unimmunized or under-immunized students require a letter of explanation of medical or religious exemption.

**FIRST NAME:** ___________________________  **LAST NAME:** ___________________________  **DATE OF BIRTH:** ___/___/___

### REQUIRED IMMUNIZATIONS:

**TETANUS/DIPHTHERIA/ACELLAULAR PERTUSSIS** (Tetanus must be within the last 10 years)

Primary series

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| Tetanus | ___ | ___ | ___ | ___ | ___ |
| Tdap | ___ | ___ | ___ | ___ | ___ |

**MEASLES, MUMPS, RUBELLA (MMR)** 2 doses required.

MMR #1 ___/___/___ (First dose must be after age 12 months)

MMR #2 ___/___/___ (Must be at least one month after dose #1)

**MENINGITIS VACCINE**

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Required within the last 5 years

**VARICELLA** (2 required)

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OR Had the disease ___/___/___

**HEPATITIS B**

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(Must be at least 1 month after #1)

(Must be at least 2 months after #2 and 4 months after #1)

**HUMAN PAPILLOMAVIRUS VACCINE**

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**HEP A:**

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**Tuberculosis testing:** A mantoux is **only** required for students determined to be at high risk for tuberculosis. A chest film is required for any **positive** PPD     PPD Date ___/___/___ mm_______ chest X ray_____

Treatment dates__________________________________________________________

**Physician Phone number**_________________________  **Fax number**_________________________

**Address**____________________________________________________________________________________

**Physician’s Signature**_________________________  **Date**_________________________
Name ________________________________________
DOB ___/____/____ Date ______________________

MEDICAL CONDITIONS

I have this “Med-Alert” Condition: ________________________________

I have been prescribed an EpiPen: Yes ☐ No ☐
If yes, EpiPen form must be completed by your physician and returned.

List Medication Allergies: ________________________________________
List Other Allergies: ____________________________________________
Acute Health Issues: ____________________________________________
Current Medications/supplements: _________________________________

SCREENING QUESTIONS

1. Does student have physical limitations? ____________________________
   Yes ☐ No ☐

2. Is student receiving or has student ever received treatment or counseling
   for mental health issues? ________________________________________
   Yes ☐ No ☐

3. Has student had any surgeries, or hospitalizations, or serious illnesses? ____________________________
   Yes ☐ No ☐

4. Does student have any health concerns that require assistance while on campus?
   If yes, explain: _______________________________________________
   Yes ☐ No ☐

PERSONAL MEDICAL HISTORY

Check the box below if student has had any problems in the following areas. Comment on all checked boxes in the space provided (attach an additional sheet if needed).

☐ Childhood Illnesses (whooping cough, chicken pox, rheumatic fever, etc.):

☐ Neurological (headaches, migraines, seizures, head injury, paralysis, etc.):

☐ Ears, Nose, Throat, Mouth (ear infections, hearing loss, sinusitis, tonsillitis, dental issues, etc.):

☐ Eyes (visual impairment, contact lenses or glasses, infections, etc.):

☐ Heart (palpitations, dizziness, fainting, arrhythmia, high/low blood pressure, etc.):

☐ Lung (shortness of breath, chest pain, asthma, infections, cough, etc.):
   ☐ Student has had a positive skin test for tuberculosis (TB)

☐ Musculoskeletal (broken bones, dislocation, scoliosis, weakness, etc.):

☐ Gastrointestinal/Metabolic (abdominal pain, diarrhea, constipation, significant weight gain/loss, diabetes, thyroid, etc.):

☐ Genital/Urinary (Urinary tract infections, kidney stones, gynecological problems, etc.):

☐ Skin (rash, eczema, herpes, etc.):

☐ Psychological (ADHD, anxiety, mood disorder, eating disorder, sleep problems, etc.):

Please provide additional information on all checked boxes including diagnosis, treatment and dates. (Use separate sheet if necessary).

_________________________________________________________________

_________________________ ______________________
_________________________ ______________________
EpiPen Form

This form is to be completed by the physician prescribing the EpiPen.

Name of Student: __________________________________________ Date of Birth: __________________________________________

Identified allergens: __________________________________________

Date of first allergic reaction: __________________________________________

Symptoms experienced: __________________________________________

Initial symptoms requiring EpiPen treatment: __________________________________________

Number and type of subsequent reactions: __________________________________________

Number of episodes when EpiPen was administered: ________ Date of most recent administration: __________

Have any allergic reactions required hospitalization? Yes ☐ No ☐ If yes, please describe:
__________________________________________________________________________________________
__________________________________________________________________________________________

Has this student received training on self-administration of the EpiPen? Yes ☐ No ☐
If yes, date: ________ Have they ever self-administered the EpiPen? Yes ☐ No ☐

Method of allergy testing: Blood ☐ Skin ☐

Asthma: Yes ☐ No ☐

Current allergy treatment:
__________________________________________________________________________________________
__________________________________________________________________________________________

Other treatments to be administered?
__________________________________________________________________________________________
__________________________________________________________________________________________

Is there any other information that may be useful in treating this student?
__________________________________________________________________________________________
__________________________________________________________________________________________

Healthcare Provider Signature: ____________________________ Print Name: ____________________________

Date: _______________ Phone: _______________

If applicable, please return the completed form to:

The Wellness Center
Bard Academy/Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 413-528-7353     F: 413-528-7358
wellnesscenter@simons-rock.edu
Health Services at the Wellness Center
CONSENT AND INFORMATION FORM
(For student to read and sign)

General Information
Health Services is available to all currently enrolled Simon’s Rock students who have paid the student health insurance fee. The Health Services’ hours of operation are Mon-Fri. 9am-5pm. The Health Services office is closed on weekends and during all school vacations.

Urgent Care and Emergency Services
Health Services provides urgent care coverage for weekends and nights when school is in session through an on-call nurse. The on-call nurse can be contacted through the Resident Directors or Security.

Making appointments
Walk in appointments are always welcome and we will do our best to see you as soon as possible. Appointments can be booked through the Front Office Manager for a specific nurse or the physician.

Health Insurance/Cost
All medical care provided at Health Services will be covered by the school health insurance. The school health insurance will cover medication prescriptions issued from Health Services and outside providers with a copay which is charged to the student’s account. In the event you are referred to an outside provider or have an Emergency Room visit, your home insurance and the school health insurance will be billed. For further information regarding the school health insurance, contact Consolidated Health Plans at 1-800-633-7861 (consolidatedhealthplan.com) or the Wellness Center at 413-528-7353.

Confidentiality
Privacy of your health information is one of our top priorities. Other than as described in Exceptions to Confidentiality, no one outside of Health Services staff will have access to your medical information including parents, faculty, student life staff, other students, or school administration without a student’s explicit written permission. To maintain continuity of care, all Health Services personnel will have access to your medical record. If you are referred to a medical provider outside of Health Services, medical information regarding the specific referral will be shared with the outside provider. Basic medical information will be shared with insurance companies to facilitate billing. If the student and provider deem it necessary to share medical information with someone outside of the Wellness Center, a student will be asked to sign an authorization form to release the information. Voice mail and e-mail communications to students will not include personal health information to maintain privacy.

Collaborative Treatment and Shared Space
The Health and Counseling Services offices reside together in the Student Union. Our philosophy of practice assumes an integrated, whole person approach which includes sharing relevant health information in order to create a coordinated plan to best support a student’s wellness.

Exceptions to Confidentiality
There are some exceptions to confidentiality. In situations in which there is evidence of a threat of serious harm to oneself or another, the medical staff is required to take action/disclose information to protect the person at risk of harm. When there is information about, or strong suspicions of physical or sexual abuse or neglect of a minor, this must be reported to the Department of Social Services. In certain legal situations, including court order, a medical provider may be required to disclose information. In addition, any time a student is admitted to the Emergency Room, the medical staff will contact the student’s parents. This is a policy of Bard College at Simon’s Rock and is in the student handbook.

I have read and understand the information above.

Student Signature: ___________________________ Print Name: ___________________________ Date: ____________

10-1-14
Dear Academy Parents,

Starting in the fall of 2017, Bard Academy will implement a new Medication Policy for Academy students. As such, all Academy students will be required to complete a Medication Inventory and Medication Agreement. The goal of the policy is to enhance the health and safety of Academy students.

Residential students of the Academy will be permitted to have prescription medications in their rooms with the exception of psychotropic medications, such as stimulants (Ritalin, Concerta, Vyvanse, Adderall, etc.), opiate pain medication (Percocet, Codeine, Vicodin, etc.), anxiety medications (Xanax, Ativan, Klonipin, etc.), antipsychotics (Seroquel, Abilify, etc.), and sleeping pills (Ambien, Restoril, etc.). Residential students, who are prescribed psychotropic medication, must additionally complete a signed Psychotropic Prescriber Authorization.

Psychotropic medications will be held and dispensed by the Wellness Center staff daily, Monday through Friday. Weekend medications will be dispensed on Friday. It will be the responsibility of the student to pick up the medication and take it at the prescribed time. Parents/guardians will be notified, if student compliance is inconsistent.

To provide medication administration, we will require paper prescriptions from your provider for submission to our local pharmacy, Lenox Village Integrated Pharmacy. The pharmacy delivers medication daily Monday through Friday. We ask that you bring prescriptions with you with enough refills for the semester. Please note that stimulant medication can be filled for only 30 days at a time and refills are not accepted. Our medical staff, in cooperation with your home prescribing physician, can assume monthly prescribing during the school year, if needed.

It is important that your student arrives on campus with sufficient medication for the first week while we process their prescriptions. Please keep a supply of your student’s medication for use on weekends and vacations, as we will not routinely send pills home for these occasions unless we have a written, signed authorization from you, in sufficient advance of student departure.

All forms must be completed prior to registration. Please send, scan or fax the forms to the Wellness Center, and let us know if you have any questions.

Sincerely,

Diane Piraino, MD, Campus Physician and Sharon Hartunian, LICSW, Director of the Wellness Center

Required medication forms enclosed:

- Medication Inventory (all Academy students)
- Medication Agreement (all Academy students)
- Psychotropic Prescriber Authorization (all residential Academy students on psychotropic medications)

Please return the completed forms to:

The Wellness Center
Bard Academy/Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 413-528-7353 F: 413-528-7358
wellnesscenter@simons-rock.edu
Medication Inventory

Student’s name ___________________________ Date of birth (mm/dd/yy) ________________
    last     first     middle initial

Medication includes both prescription and non-prescription medications and includes those taken by mouth or by inhaler, those which are injectable, applied as drops to eyes or nose, or applied to the skin.

PRESCRIPTION MEDICATIONS
If the residential student is taking psychotropic medication the prescribing provider must complete and return the Psychotropic Prescriber Authorization. Commuter students are exempt from completing the Psychotropic Prescriber Authorization form.

All prescription medications must be registered with the Wellness Center. All psychotropic medications, such as stimulants, antidepressants, anti-anxiety medication, and pain medication must be held and dispensed by the Wellness Center. All prescription medications must be in original pharmacy containers, labeled by the pharmacy, with the name of the student, the prescribing physician, medication, instructions for use, and the expiration date. It is the responsibility of the student to pick up prescription medication from the Wellness Center. The Wellness Center does not remind or compel students to take prescription medication.

PLEASE LIST PRESCRIPTION MEDICATIONS:

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NON-PRESCRIPTION MEDICATIONS
The Wellness Center provides items such as mild pain relievers, cough suppressants, etc. If students do need to bring special products, please list them below, including all over-the-counter medications, vitamins, skin preparations, herbal items, and food supplements.

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NO MEDICATION
☑ Please check here to indicate that you will be bringing no medications (including prescription, non-prescription, and herbal supplements).

PARENT ACKNOWLEDGEMENT
By signing below, I acknowledge that I have read Bard Academy’s medication policies and agree to comply with them. The responses on this Medication Inventory are true and complete to the best of my knowledge. I authorize the Wellness Center to administer prescription medication to the student as listed above.

Parent’s signature (if student is under 18) ___________________________________________ Date _____________

Student’s signature ___________________________________________ Date _____________
NAME: ___________________________________________________  DOB: _________________________

MEDICATION AGREEMENT

For students living on campus, it is often easier to have existing prescriptions filled at a local pharmacy. Lenox Village Integrative Pharmacy delivers medications to the Wellness Center on weekdays. There are other pharmacies available in Great Barrington, if students choose to obtain prescriptions independent of the Wellness Center.

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATIONS

➢ I understand that I am responsible for following my doctor’s directions for taking my medications.
➢ I will safely store prescribed and over the counter medication(s) in my room while at school.
➢ I will keep the medication in the original pharmacy-prepared container/package so that it can be easily identified.
➢ I agree to contact an adult on campus if I have an issue with medication.
➢ I will NEVER share my medication with another student.
➢ I will report lost or stolen medication to Security or the Wellness Center immediately.
➢ I understand that if I do not follow the above agreements I may be subject to the College/Bard Academy’s disciplinary action.
➢ By signing below, I understand and agree that it is my responsibility to ensure that my prescribed medication(s) is/are being administered in accordance with my medical provider(s)’ order(s).

________________________   ___________________________   ___________
Student Signature         Print Name               Date

PARENTAL CONSENT FOR SELF-ADMINISTRATION OF MEDICATIONS

I give permission for my child to self-administer prescribed as well as over the counter medications. I understand and agree that it is my child’s sole responsibility to ensure that the medication(s) is/are being administered in accordance with the medical provider(s)’ order(s) or the manufacturer’s directions. I understand and agree that the Wellness Center is not responsible for my child’s failure to follow prescribing orders or for the consequences of such failure.

________________________   ___________________________   ___________
Parent/Guardian Signature  Print Name               Date

CONSENT FOR OTC MEDICATIONS

I give permission for my child to access over the counter medications (for example Tylenol, Ibuprofen, Benadryl) through Campus Life Staff or Security when the Wellness Center is closed.

________________________   ___________________________   ___________
Parent/Guardian Signature  Print Name               Date
PSYCHOTROPIC PRESCRIBER AUTHORIZATION

I am a health care provider for the student identified below and I have prescribed psychotropic drugs for the student. I understand that the student plans to attend Bard Academy, a demanding residential academic environment with limited structure and supervision. I understand that the Wellness Center at Bard Academy will administer the prescription medication to the student, but that it is the responsibility of the student to obtain and take medication. The Wellness Center will not remind or compel students to take prescription medication. In my judgment, the student is able to participate in the Bard Academy program.

This form is to be completed by the student’s health care provider or mental health clinician who prescribes the psychotropic medication(s).

Student Name: ___________________________ DOB: __________________

Psychotropic Drug(s) and dose(s): _______________________________________

________________________________________________________________________

Clinician Name and Degree: _______________________________________________

Clinician Address: _________________________________________________________

Clinician Phone: ___________________________ Fax: _________________________

Clinician Signature: ________________________________________________________

Please return form directly to:

Bard Academy
The Wellness Center
84 Alford Rd.
Great Barrington, MA
01230

wellnesscenter@simons-rock.edu
P: 413/528-7353
F: 413/528-7358