

FALL 2010

Dear Students and Parents:

We are looking forward to seeing you soon. We have enclosed required medical forms that must be completed and returned to us by July 15, 2010. Early completion and return of these forms makes registration day easier.

1. (For Continuing Students Only) **Continuing Student Update Form** - Please update this form and complete the required medical forms as indicated below.

2. (New Students) **Family Information Form** - Complete all family information as outlined on this form.

3. (New International Students) **International Student / Guardian Form** - Complete information as outlined on this form.

4. (All New Students) **Medical Insurance Coverage, Student Injury & Sickness Plan, Private Insurance Information – All Students** must be covered by medical insurance. Parents can use their own health insurance plan provided that it is a PPO or, if it is an HMO and the primary physician is listed as Dr. Joseph Atiyah, M.D., (our local Idyllwild physician). Idyllwild Health Center (our local clinic) will not accept medical insurance policies issued in a foreign country or from a company outside of the United States. If your child is taking medication, then your insurance must be accepted by the SchoolMed Program as well. If your health insurance plan is not a PPO and your primary care physician cannot be changed to the Idyllwild Health Center, then Student Insurance (through Clifford Allen and Assoc.) must be purchased. See the enrollment form in this packet.

5. (All New Students) **Medical Insurance and Credit Card Information Form** – U.S. medical insurance and credit card information must be provided for all students enrolled for the Fall 2010 academic year. This form must be complete and a copy of the health card and credit card (front and back) must be attached to this sheet.

6. (All Students - *these forms must be filled out and signed by your physician annually*) **Consent to Treat Form, Immunizations, Medical History, Physical Exam, Physician's Medication Order Form, Parents Medication Consent Form** – These forms expedite the process of obtaining medical care, especially for emergency situations. It is for this reason that the student will not be allowed to participate in school until these forms are on file at the health center.

A TB skin test must be given upon enrollment at Idyllwild Arts Academy. **It is imperative that the results of the TB test be included on the Immunization form!**

California State law requires that before starting classes, a California School Immunization Record be on file. This form is completed by school personnel based on official written documentation. We therefore require that you submit a copy of your child's immunization record, school immunization record, or pediatrician's record. Any immunization boosters must be noted in the same manner for subsequent years.

Upon admission, any incomplete test exam or immunizations will be scheduled and performed at the parent's expense.

7. (All Students – *this form must be filled out annually*) **Influenza Vaccine Consent** – Although this vaccination is optional, it is highly recommended for persons living in boarding institutions such as the Idyllwild Arts Academy. We have found that when this vaccine has been given to the majority of the students, the number of cases has been reduced and the symptoms for those infected have been less severe and of shorter **duration**.

8. **SchoolMed Medication Registration** (information and FAQ's) – Parents must register all medications that their child takes, both daily and those taken on an as-needed basis, with the SchoolMed Company. If these forms are applicable to your child, please follow the instructions or call SchoolMed directly at (954) 916-4990.

Additionally, we ask for your cooperation in updating the Health Center concerning any injuries that occur or any continuing medications or treatments that may be prescribed at any time during the year. Your help and cooperation in this matter will be very much appreciated. If you have any questions concerning these forms or procedures, please call me at extension 2275.

Sincerely,

Rebecca F. Sandlin, R.N.
School Nurse

CONTINUING STUDENT UPDATE SHEET

STUDENT

NAME _____ DOB _____

FOR ACADEMIC YEAR _____

FAMILY INFORMATION FORM:

No changes

Update: (student)Cell phone _____

Email _____

(mother) addresses: Home: _____

Phone, cell, fax _____

Email _____

Business: _____

Phone, fax _____

(father) addresses: Home: _____

Phone, cell, fax _____

Email _____

Business: _____

Phone, fax _____

GUARDIAN:

No changes

Update: Name _____

Address/Phone _____

Email _____

STUDENT MEDICAL INSURANCE: (if updated, please attach front/back copies of medical card)

Enroll in Student Insurance (12 months, \$1,500.00, 9/01/10 – 8/31/11)

No change to private insurance

Update private Insurance:

_____/_____/_____
Name of insurance Policy # Group #

CREDIT CARD INFORMATION: (EXPIRATION DATE MUST BE VALID THROUGH 7/11)

No Change

Update: (if updated, please attach front/back copies of card to this sheet)

Card Type _____ Card # _____ Exp. Date _____

Name on card _____

FAMILY INFORMATION FORM – 2010-2011

(please print or type – do not use pencil)

Boarding Day

Student's Name _____

Date of Birth _____ Social Security # _____

Country of Birth _____ Country / Passport # _____

Student resides with: Mother Father Both Guardian (**please see back of form**)

Correspondence (grades, advisor letters, etc.) should be sent to: Mother Father Both Guardian

Student e-mail _____ Educational Consultant (please see back of form)

Student cell phone # _____ (**required for Emergency Action Plan**)

Custodial parent ? YES NO Please attach court custody documents, if possible

Father's Name _____

Address- Street: _____

City: _____ State: _____ Country: _____ Zip: _____

Phone* () _____ Cell () _____

E-mail _____ Fax*() _____

Occupation and position _____

Name of Firm _____

Business Address _____

Bus. Phone* () _____ Bus. Fax*() _____

Custodial parent ? YES NO Please attach court custody documents, if possible

Mother's Name _____

Address- Street: _____

City: _____ State: _____ Country: _____ Zip: _____

Phone* () _____ Cell () _____

E-mail _____ Fax*() _____

Occupation and position _____

Name of Firm _____

Business Address _____

Bus. Phone* () _____ Bus. Fax*() _____

***International students: please indicate country and city code**

INTERNATIONAL STUDENT / GUARDIAN FORM – 2010—2011

Name of Student _____

Name of Guardian _____

Address of Guardian:

Street: _____

City: _____

State: _____ Zip Code: _____

Phone: Home: _____

Work: _____

Fax: _____

E-mail: _____

During our vacations, our dormitories are closed. Students may not stay on campus. Guardians are responsible for providing or arranging placements for students during Idyllwild Arts Academy vacation times. If your child's guardian is unable to assume responsibility for arrangements during vacations, please indicate someone else who could provide your child with a place to stay.

Our vacations are: 1 week for Fall Break / Thanksgiving
 3 weeks for Winter Break / Christmas
 2 weeks for Spring Break

If you have specific questions about actual dates of vacation for this year or any other areas addressed on the form, you may consult the school calendar or contact the Dean of Student's office at the Idyllwild Arts Academy.

INTERNATIONAL STUDENT EDUCATIONAL CONSULTANT FORM

Name _____

Position _____

Name of Firm _____

Business Address _____

City _____ State _____ Zip _____

Phone* () _____ Fax* () _____

* Please indicate country and city code E-mail _____

IdyllwildARTS ACADEMY

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STUDENT MEDICAL INSURANCE COVERAGE 2010-2011 (FALL)

Dear Parents/Guardians:

As you are aware, Idyllwild Arts Academy is in an isolated location and there are limited medical facilities in the town of Idyllwild. Out of concern for the health and welfare of our students we have established a policy that **every student enrolled must be covered by a medical insurance plan accepted by the local medical clinic, Idyllwild Health Center.**

Idyllwild Health Center is operated by Drs. Kamran Qureshi, M.D. & Joseph Atiya, M.D., PO Box 3152, Idyllwild CA 92549 (951) 659-4908. This clinic accepts many Preferred Provide Plans; PPO and a few local (So. Calif.) HMO plans. The Idyllwild Health Center does NOT accept medical insurance issued in a foreign country or from a company outside the United States (i.e. CHUBB, AIG, International Health Insurance, DEBEKA, etc.). Whether you have insurance accepted by Drs. Qureshi & Atiya or you choose to enroll your student with the Student Insurance Program **you must** fill out your Credit Card information on the sheet attached. The credit card you provide (VISA, MasterCard, AMEX) must be valid through July 2011 and a signature authorizing the use of the credit card for medical reasons.

If there is any question about your student's coverage for routine medical care under the insurance you have or are planning to maintain, it is your responsibility to contact Idyllwild Health Center and/or your insurance carrier and ensure that Drs. Qureshi and Atiya are accepted providers for routine medical treatment. Most HMOs and PPOs will cover emergency treatment when traveling, but NOT routine care when in residence out of your home area.

To help you meet this financial responsibility, we have found a medical insurance plan that provides excellent primary insurance coverage. This plan is for all international students and those who do not have medical insurance coverage outside of their local area. This plan was designed especially for private secondary schools and meets mandated requirements for California. The rates for this plan are included on the attached page. After reading through this plan, if you have any other questions with regards to coverage provided, contact Cliff or Ford Allen at (888) 342-2224. Please do not call us, as we do not have detailed information with which to answer your coverage questions.

All international students will be enrolled in Plan I, 12 months. Domestic families with HMOs, PPOs or managed care network programs may want to consider Plan I to reduce your paperwork and issues involved with obtaining reimbursements for treatment. In most cases your up-front deductibles and co-payments may increase so much that you may want to have primary first dollar coverage as provided under Plan I.

Parents/Students are required to provide proof of an acceptable insurance plan and valid credit card information by registration. All parents **must** complete the attached form (Student Injury & Sickness Plans: 2010-2011 School Year). **If we do not have this information we will purchase Student Medical Insurance for your student on your behalf and you will be billed for the cost of the premium.** This cost is not refundable.

**STUDENT INJURY & SICKNESS PLAN
2010-2011 (FALL)**

Dear Parents/Guardians:

Out of concern for the health and welfare of all our students, Idyllwild Arts Academy requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by local providers and practitioners. While most USA families are insured under managed care programs (HMOs, PPOs, etc) such “network plans” often create severe bureaucratic and cumbersome administrative problems and procedures. In many cases these plans do not provide coverage for your child when away from home, and if they do you are faced with up-front deductibles and co-payments not required when your child is home. **It is your responsibility to contact your insurance company to discuss what benefits will be lost and what deductibles and co-payments will be required when your child leaves home.**

Please note that our local health center will not accept medical insurance policies issued in a foreign country or from a company outside the United States.

PREMIER HEALTH PLAN I (Primary Coverage)

Provides primary, first dollar benefits for those of you who do not have any insurance or whose coverage is not accepted outside your geographical area. If your child is not insured as a dependent on your insurance policy, or your child is a non-USA resident, you must select this plan. This plan will cover students anywhere in the world. This plan was designed especially for private secondary schools.

You must select one of the following options provided below and complete the Credit Card Information on the page attached.

STUDENT INJURY & SICKNESS PLAN:

1. Enroll (Student Name) _____ in PLAN I for:
(ALL INTERNATIONAL STUDENTS MUST ENROLL)
 - 12 months
2. In making this selection, I accept full responsibility for all medical costs incurred by my child. My (PPO, HMO) plan is as follows: **(NOT FOR INTERNATIONAL STUDENTS)**

Plan name I.D. # Group #

Signature of Parent or Guardian

Date

***** To Read details of the 2009-2010 Student Injury and Sickness Insurance Plan see page 16 (at the end of the forms section.)***

**IDYLLWILD ARTS STUDENT MEDICAL INSURANCE AND CREDIT CARD INFORMATION
2010-2011**

PART I

STUDENT NAME: _____
(Print) Last Name / First Name / Middle Name

**** Please check one ****

I do not have a medical insurance plan accepted by Idyllwild Health Center, and do hereby authorize Idyllwild Arts Academy to purchase the Student Health Plan (UnitedHealthcare) for this student, and charge my account

Signature of Parent or Guardian Date

**** (ALL INTERNATIONAL STUDENTS MUST ENROLL) ****

Plan I

I have verified that Idyllwild Health Center accepts my private medical insurance:
**** ATTACH A CLEAR COPY OF THE FRONT AND BACK OF THE INSURANCE CARD ****

**** Please Print Clearly ****

Name of Insurance Company _____

Address of Insurance Company _____

Policy Number: _____ Policy Holder: _____

Employer: _____

IF YOU HAVE NOT VERIFIED THAT YOUR MEDICAL PLAN IS ACCEPTED BY IDYLLWILD HEALTH CENTER, PLEASE DO SO BY CALLING THEIR OFFICE AT (951) 659-4908. PLEASE NOTE THAT IDYLLWILD HEALTH CENTER DOES NOT ACCEPT INSURANCE ISSUED BY COMPANIES OUTSIDE THE UNITED STATES.

PART II

******* ATTACH A CLEAR COPY – FRONT AND BACK – OF YOUR CREDIT CARD *******

And complete the following: (check one)

Type of Card: Visa _____ Mastercard _____ American Express _____

Account #: _____

Expiration: _____ (**Must** be valid through 7/01/10)

Name on Account: _____

I hereby authorize Idyllwild Arts to utilize the above referenced account for routine medical charges incurred on my student's behalf. Emergency services are to be covered through existing insurance coverage on file.

Signature of Parent or Guardian Date

CONSENT TO TREAT FOR: _____

2009 – 2010

Student's Name

Date of Birth

ALLERGY _____

Pursuant to the provisions of Section 25.8 of the Civil Code of California, I (we) do hereby authorize the faculty and members of the administrative staff of Idyllwild Arts and that any adult member therefore is hereby authorized to act as agent for the undersigned during the school year to consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any dentist, physician, chiropractor or surgeon licensed under the Provisions of the Medical Practice Act of Dental Practical Act on the medical or dental staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at such a licensed hospital. I (we) give consent formental health treatment, counseling, psychological and/or psychiatric evaluation and treatment provided by the mental health staff of Idyllwild Arts Academy, a licensed psychologist, and/or a licensed psychiatrist.

A reasonable effort is made to contact and inform the parents or guardian in case of emergency medical, dental, psychological, and surgical diagnosis, care, treatment and/or hospitalization is deemed necessary or advisable for the student. I (we) understand that, should a psychological evaluation be necessary for my (our) child, we will be contacted.

It is understood that this authorization is given in advance of any specific diagnosis, treatment and hospital care being required, it is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforesaid physician, chiropractor or dentist in the exercise of his best judgment may deem advisable. The undersigned do(es) hereby indemnify and hold harmless Idyllwild Arts and all members of the faculty and administrative staff thereof from any financial responsibility for so acting and the undersigned agree(s) to pay the reasonable and customary charges for any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care provided to said minor pursuant hereto.

This also authorizes Idyllwild Arts to purchase medical and accident insurance for all students with coverage needs at the school's discretion.

In order that the student, faculty, members of the administrative staff, and parents be fully protected, each student must be covered by medical insurance while at Idyllwild Arts. If, at any time, it is determined that the student is not adequately covered by medical insurance, the undersigned hereby authorizes Idyllwild Arts, at its discretion, to purchase such insurance and, in that event, the undersigned agrees to be responsible for the insurance premiums and any and all other charges incurred in connection therewith.

Bill Lowman or his authorized representative may act in my behalf, signing any required documents, to apply for a medical plan for my child.

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

IMMUNIZATION RECORD**2009-2010**

To the physician: Please fill in the following immunization dates or attach an office copy that includes the up-to-date immunization listed here. Please include the month/day/year for each vaccine administered.

STUDENT'S NAME: _____ **DATE OF BIRTH:** ___/___/___

ALLERGIES _____

The following immunizations are required by law in the state of California. No student will be permitted to commence classes without a completed immunization record per California regulation. Exceptions will be made only for religious or medical contraindication. Physician signature required below.

TB Skin Test: (only required upon admission to school) Must have been done after Mar. 1, 2010			
Date administered:	Date read:	In duration:	Result:
Vaccine	Mm/dd/yy	Vaccine	MM/DD/YY
Polio ₁		Hepatitis _{b1}	
Polio ₂		Hepatitis _{b2}	
Polio ₃		Hepatitis _{b3}	
Polio ₄		MMR ₁	
Polio ₅		MMR ₂	
DTaP/DTP/DT ₁		Varicella ₁	
DTaP/DTP/DT ₂		Varicella ₂	
DTaP/DTP/DT ₃		OR date of disease	
DTaP/DTP/DT ₄			
DTaP/DTP/DT ₄			
Last tetanus within 10 years			

The following immunizations are not required, but are highly recommended for dormitory living conditions:

Vaccine	Mm/dd/yy	Vaccine	Mm/dd/yy	Vaccine	MM/DD/YY
Hepatitis A ₁		HIB ₁		HPV ₁	
Hepatitis A ₂		HIB ₂		HPV ₂	
		HIB ₃		HPV ₃	
		HIB ₄		Meningococcal Meningitis	
		HIB ₅			

Examining Physician: _____ Address: _____

Signature: _____

Date: _____ Phone: _____

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MEDICAL HISTORY**2010-2011**

To be filled out by student's parent/guardian, must be completed before appointment for physical exam

Student's Name: _____	Date of Birth: ____/____/____
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Allergies (please write specific allergen in space provided):

Foods:
Medications:
Other:

Indicate medical history by filling in appropriate box with year (if applicable)

Blood/Cancer	Year	Mental Health	Year
Anemia		Depression	
Cancer (type)		Anxiety	
Hemophilia		Eating issues	
Ear, Nose & Throat		Insomnia	
Hearing impairment		Alcohol, drug, or smoking	
Sinus problems		Behavioral issues	
Seasonal allergies		Neurological	
Eye		Cerebral palsy	
Specify problem		Migraine headaches	
Endocrine		Multiple sclerosis	
Diabetes		Seizures or Epilepsy	
Thyroid		ADD / ADHD	
Gastrointestinal		Other (specify)	
Heart		Orthopedic	
Hiatal hernia or Reflux		Fractures (type, Location)	
Irritable bowel syndrome		Sprains / Strains:	
Hospitalization		Reproductive	
Nature of admission		Severe menstrual cramps	
Date		Irregular periods	
Facility		Ovarian Cyst	
Kidney		Skin	
Physician name & contact info		Eczema	
		Psoriasis	
Lungs		Surgery	
Kidney stones		Nature of surgery	
Recurrent urinary tract infection		Date	
		Facility	
Treatment Program		Surgery	
Asthma		Nature of surgery	
Chronic bronchitis		Date	
Tuberculosis		Facility	
Other (specify)		Physician & contact information	

Parent / Guardian Signature

Date

PLEASE SEE OTHER SIDE

PHYSICIAN'S REPORT

2010-2011

To be completed by physician: Please review the student's history and complete this physician's form commenting on all "yes" answers. Also complete the attached Immunization record. This information is strictly for the use of Student Health Services and will not be released without parent/student consent.

Student's Name: _____

Date of Birth: ____/____/____

ALLERGIES

Sex: **O F O M** Height: _____ inches Weight: _____ pounds
Pulse: _____ Respirations: _____ B/P: _____
TB skin test: (only required upon admission to school) Date administered: _____ Date read: _____
Mm: _____ Result: **O Neg O Pos**

Varicella: Has student had disease? _____ Date of disease? _____
Urinalysis: Sugar: _____ Albumin: _____ Micro: _____
Hemoglobin or Hematocrit: _____

Are there alterations of the following system? Describe fully. Use additional sheet if needed.

SYSTEM	YES (GIVE DETAILS & DATES)	NO
Head, ears, nose, throat		
Eyes		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological		
Skin		
Any other condition		
Prescription medication	Please fill out Physician's Medication Order Form	

Please summarize condition, length of time it has existed and treatment. Use additional sheet if needed.

CONDITION	DATE, FACILITY, PHYSICIAN NAME & CONTACT INFORMATION	NO
Depression		
Anxiety		
Insomnia		
Eating disorder		
Alcohol, drug, or smoking issues		
Behavioral issues		
Hospitalization for above		
Treatment program for above		
Psychotropic medication	Please fill out Physician's Medication Order Form	

For hospitalizations or participation in treatment programs within the past twelve months, a detailed physician's report stating a)reason for admission, b)treatment program and c)discharge summary must be attached.

Additional comments: _____

Examining Physician: _____

Address: _____

Signature: _____

Date: _____

Phone: _____

PLEASE SEE OTHER SIDE

PHYSICIAN'S MEDICATION ORDER FORM

2010-2011

This form must be completed, signed by the physician and returned even if student takes no medication. A comprehensive written report from a psychiatrist is required for all psychotropic medications.

Student's Name _____ **Date of Birth** ___/___/___

ALLERGIES: _____

The above student is currently taking medication(s) Yes No

	Medication	Dosage	Frequency	DX

Diagnosis: _____

Name of licensed prescriber (please print) _____

Title _____

Business telephone number _____

Emergency telephone number _____

Specific directions or information for administration

Side effects, contraindications, or possible adverse reactions to be observed

Any other medical conditions

Examining Physician _____ Address _____

Signature _____ _____

Date _____ Phone _____

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PARENTS' MEDICATION CONSENT

2010-2011

This form must be completed, signed by parent/guardian and returned even if student takes no medication.

Student's Name _____ Date of Birth ____/____/____

ALLERGY _____

My child/ward is currently taking the following medication(s):

- 1. None
- 2. _____
- 3. _____
- 4. _____
- 5. _____

If your child is taking medication, please fill out the rest of the form and ask your child's physician to fill out the *Medication Order Form* attached to the *Medication History* packet.

For psychotropic medication, include the physician's medication order and a detailed written evaluation as reviewed in the *Student/Parent Handbook*.

All regularly taken medications MUST be submitted to SchoolMeds pharmacy for dispensing. See the following page for instructions. If student's current insurance program does not cover SchoolMeds pharmacy services, parents will be required to purchase the school health insurance policy.

I understand I may retrieve the medication from the school at any time. However, the medication will be destroyed if it is not picked up or requested to be mailed within the U.S. within one week following termination of the order or one week beyond the close of school term for the student.

Parent/Guardian Signature Date

INFLUENZA VACCINE CONSENT FORM
2010 – 2011

_____ / ____ / _____

Student Name

Date of Birth

_____ I am requesting the administration of the influenza vaccine for my son/daughter. He/she has no known allergy to the following: chicken feathers, chicken eggs, or chicken dander.

I am aware of and understand these uncommon but possible adverse reactions to the flu vaccine:

Fever, vague body aches, muscular pains, and other systemic symptoms may occur during the first 6 – 12 hours after vaccination and may persist for one or two days.

Immediate, presumably allergic responses such as appearance of flare and wheal or various respiratory problems may develop and are indicative of sensitivity to the components of the serum derived from residual egg protein. This type of response is exceedingly uncommon.

Neurological disorders, including encephalopathy and ascending paralysis, have been know to have a temporal association with the administration of the flu vaccine. These conditions are usually self-limiting and reversible and their occurrence is very rare.]

_____ I do not wish my son/daughter to be vaccinated for influenza

Signature of Parent/Guardian

Date

Office Use Only

Date Administered

Location

Mfg

Lot #

Nurse Initials

SCHOOLMED

Pre-packaged medications for students

Dear School Parents,

This coming school year, Idyllwild Arts Academy will continue **requiring** school families to register for the service of **SchoolMed** to dispense and package all of your student's medication in pill form while at school. **All pills that your child takes on a daily or as needed basis** will be dispensed by our pharmacy and individually packaged, sealed and sorted according to day and time of administration. This includes prescription, non-prescription pills and vitamins. Each packet will be labeled with your child's name, medicine, dosage, date and time to be given. Our system ensures that each student receives their correct medicine at the correct time.

The pharmacy will dispense and ship all medicine in 30 day increments directly to the school on a monthly basis. The initial shipment of meds will be sent to the school prior to your child's arrival. You will be notified by email when **SchoolMed** receives your initial prescriptions and when those meds are shipped to school.

What you need to do:

1. Register on www.SchoolMed.com – note your order number.
2. Print out receipt from your online registration.
3. Get original prescriptions for ALL meds (prescription and non-prescription) written with enough refills for the entire school year. Bring enclosed Physician Instruction letter.
NOTE: under law Controlled Substances may not be written with refills. A new prescription is required for each 30 day supply and MUST be sent to SchoolMed on a monthly basis. You are encouraged to send multiple 30day prescriptions at a time. They will not expire, as the pharmacy is located in a state where they have up to 6 months to fill prescriptions.
4. Make certain prescriptions are written exactly the way your child takes the medication.
5. Write the order number on top of each original prescription.
6. Include a copy of both sides of your insurance/prescription card that covers the meds.
7. Mail directly to: **SchoolMed**, P.O. Box 267037, Ft. Lauderdale, FL 33326-7037.

Fees: There is no additional fee to you for our medication packaging service. Your school will be paying the monthly packaging/shipping fee.

Deadlines: ALL OF THE ABOVE ITEMS MUST BE RECEIVED 30 EDAYS PRIOR TO STUDENT'S START DATE. A **late fee of \$25.00** will be charged to your credit card if any of the items above are received after the deadline.

Med Changes: You will be charged a \$15.00 fee for each medication change, which will be charged to your credit card. In addition, you will be responsible for any shipping charges for any med that is unable to be shipped within the monthly refills due to **SchoolMed** not receiving prescriptions that may be needed.

Insurance/Prescription Meds: Our pharmacy partner accepts most insurance plans. They will verify your insurance and bill your insurance provider for prescription drugs. You will be responsible for co-payments and deductibles and the cost of drugs not covered by your plan. The pharmacy will not charge the initial medication charges to your credit card until after your child is in school. They will then charge your credit card every month that meds are sent to school. It is important that you notify **SchoolMed** of any changes to your credit card. If the pharmacy is not a provider for your plan, you will be notified and given the option to contact your school for alternative arrangements.

Meds Not Covered by Insurance: Will be charged to your credit card by the Pharmacy.

Please refer to our website www.SchoolMed.com for registration and details. For questions or if you are unable to register online, contact **SchoolMed** at 954-916-4990 or info@SchoolMed.com.

Turn page for FAQ's

SchoolMed FREQUENTLY ASKED QUESTIONS

1. **Exactly which medications am I required to have SchoolMed dispense?** All pills taken daily or as needed – original prescriptions required. (Your school stocks items such as Tylenol, Benadryl, Advil, etc.)
2. **Is the Pharmacy on my Insurance Plan?** The pharmacy is contracted with most insurance plans however, until you submit your registration form with a copy of your insurance card, your plan cannot be verified for billing. We will contact you if the pharmacy is not on your plan. In the rare instance the pharmacy cannot bill your insurance; you may choose to give authorization to charge your credit card for the meds. You will not be required to participate in the **SchoolMed** program if your insurance will not pay for medications dispensed by your pharmacy. Any co-pays and credit card charges from the pharmacy will appear as a separate charge after your school begins.
3. **I can only refill my child's medication when h/she is down to the last pill. How can the pharmacy send the meds to the school so far in advance?** Even though it may be too early for your refill, our pharmacy will still dispense and ship the medications to your child's school, but will not bill your insurance until the day your child begins school. Since that date will probably NOT coincide with your refill date, the pharmacy will then hold on to the claim form until the appropriate date to resubmit the claim for reimbursement. Your insurance will then be billed on a monthly basis, coinciding with the refill dates. PLEASE NOTE: Since we do not bill your insurance until your school begins you may refill your child's meds anytime before school, if needed.
4. **What if I pay one co-pay for a 90-day supply of meds?** Most of the time, the pharmacy can only dispense a 30-day supply of medication each month. Please notify **SchoolMed** if you have a 90-day plan.
5. **Can a half of a pill be packaged?** Yes
6. **My child takes a different dose of the same medicine every other day. Can it be packaged that way?** Yes
7. **Will the pharmacy dispense generic or brand?** Unless the prescription specifies, "brand only", the pharmacy will dispense the generic. Most insurance plans only pay for generic.
8. **How do I get my Physician to prescribe a controlled substance more than a month in advance?** Most states will allow for a physician to write more than one prescription at a time, as long as they are written for no more than a 39-day supply each, and are dispensed only one month at a time. The physician should NOT post-date the prescription. For example, if on May 5th your child has a physician appointment and needs a prescription for Concerta 36mg to be used at that time ask your doctor to write an additional 30-day prescription for you to send to **SchoolMed**. Both prescriptions can be dated May 5th. Even though the medication is not dispensed until the school year begins, in the state where our pharmacy is located, those prescriptions may be filled up to 6 months before expiring. Please note that Controlled Substance cannot be written with refills. Law requires a new prescription every month. Please send **SchoolMed** multiple 30-day prescriptions to avoid missing a dose of your child's medicine. **Please see Physician Instruction Letter enclosed with this information.
9. **How will my child's medication refills and changes be handled throughout the school year?** Either 1) the school physician will write all new prescriptions, medication changes, and monthly controlled substance prescriptions and send those directly to SchoolMed, or 2) the parent or responsible party will send monthly prescriptions, directly to SchoolMed. All monthly medication charges, co-pays and deductibles will be charged on a monthly basis to the responsible party's credit card.