



## MEDICAL INFORMATION

### STUDENT

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ S.S#: \_\_\_\_\_

### INSURANCE

Insurance Carrier: \_\_\_\_\_

Medicaid Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In an emergency, if I cannot be reached at the above number(s), I hereby give my consent for (1) the administration of any treatment deemed necessary by a licensed physician or dentist; and (2) the transfer to any hospital reasonably accessible.

\_\_\_\_\_  
Student Signature and Date

\_\_\_\_\_  
Parent / Guardian Signature and Date

### FAMILY PHYSICIAN

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

### MEDICAL HISTORY

Has the student ever been hospitalized or undergone surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe circumstances and give dates: \_\_\_\_\_

Has the student ever had a broken bone? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe circumstances and give dates: \_\_\_\_\_

### ATTENTION OR EMOTIONAL DIFFICULTIES

If at any time has the student been diagnosed as having attention or emotional problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

What was the diagnosis and when was it made? \_\_\_\_\_

Who made that diagnosis? \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_  
Student's Last Name

**VACCINATIONS**

Is the student up to date on all vaccinations? \_\_\_\_\_ Yes \_\_\_\_\_ No

Dates of most recent vaccinations:

- Diphtheria / Tetanus \_\_\_\_\_
- Polio \_\_\_\_\_
- MMR \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Hepatitis B \_\_\_\_\_

**DENTAL AND VISION**

Date of the last dental examination: \_\_\_\_\_

Is the student currently under treatment with an orthodontist? \_\_\_\_\_ Yes \_\_\_\_\_ No

Indicate if he is fitted with: \_\_\_\_\_ Braces \_\_\_\_\_ Retainer

Do you want the student to continue with orthodontic care while enrolled? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of last eye examination: \_\_\_\_\_

Corrected vision required: \_\_\_\_\_ None \_\_\_\_\_ Reading \_\_\_\_\_ Classroom \_\_\_\_\_ All the time Type: \_\_\_\_\_ Glasses \_\_\_\_\_ Contact Lenses

**Indicate any of the following diseases or illnesses the student now has or experienced in the past:**

- |                                   |                                   |                               |
|-----------------------------------|-----------------------------------|-------------------------------|
| _____ AIDS/HIV Positive           | _____ Anaphylactic shock          | _____ Anemia                  |
| _____ Anorexia/Bulimia            | _____ Appendicitis                | _____ Arthritis               |
| _____ Back injury                 | _____ Bladder or Kidney infection | _____ Bone condition          |
| _____ Bowel problems              | _____ Cancer                      | _____ Chest pains             |
| _____ Chicken pox                 | _____ Convulsions or seizures     | _____ Chronic cough           |
| _____ Cysts/tumors                | _____ Dermatitis (eczema)         | _____ Diabetes                |
| _____ Difficulty walking/lifting  | _____ Epilepsy                    | _____ Fainting/dizziness      |
| _____ Frequent colds/sore throats | _____ Constipation/diarrhea       | _____ Frequent ear infections |
| _____ German measles              | _____ Hay fever                   | _____ Heart trouble/disease   |
| _____ Hepatitis                   | _____ Hernia                      | _____ High blood pressure     |
| _____ Hives/skin allergies        | _____ Hypoglycemia                | _____ Headaches/migraines     |
| _____ Knee or ankle injury        | _____ Moles or lumps              | _____ Meningitis              |
| _____ Mononucleosis               | _____ Mumps                       | _____ Muscle weakness         |
| _____ Obesity                     | _____ Pneumonia                   | _____ Polio                   |
| _____ Red measles                 | _____ Rheumatic fever             | _____ Scarlet fever           |
| _____ Scoliosis                   | _____ Seizures                    | _____ Thyroid disease         |
| _____ Ulcers                      | _____ Urination problems          | _____ Venereal disease        |
| _____ Whooping Cough              | _____ Other: _____                |                               |

Please give any important details about the items you circled above: \_\_\_\_\_

Have any of the student's close relatives had any of the above diseases/illnesses? If yes, list and describe:

\_\_\_\_\_

**OTHER MEDICAL CONCERNS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# MEDICATION AND DIAGNOSIS INFORMATION

Students Name: \_\_\_\_\_ SSN: \_\_\_\_\_

## CURRENT MEDICAL CONDITION(S)

Current Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Current Health problems: \_\_\_\_\_

\_\_\_\_\_

**Allergies:** Include all known allergies to medications, foods, insect bites/stings, etc., include severity of reaction, date of last occurrence, what happened, and medication/treatment. NONE (please circle if there are no allergies)

<u>Allergy</u>	<u>Reaction/Severity</u>	<u>Date</u>	<u>Medication/Treatment</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the student use an inhaler? \_\_\_Yes \_\_\_No Does the student need to carry an Epinephrine pen? \_\_\_Yes \_\_\_No

If yes, identify and describe the condition & the medication: \_\_\_\_\_

\_\_\_\_\_

Does the student have any dietary restrictions? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please identify and describe: \_\_\_\_\_

## CURRENT MEDICATIONS PRESCRIBED

<u>Medication</u>	<u>Taken for</u>	<u>Prescription</u>	<u>Current Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## CONSENT TO MEDICAL TREATMENT

I agree to medical treatment provided by Dr. Ritchie, Family Practice and Dr. Jacobs, Psychiatry. One admitting visit is required with follow-up only as medically necessary.

\_\_\_\_\_

\_\_\_\_\_

Student/ Signature and Date

Parent / Guardian Signature and Date

