STUDENT MEDICAL FORM

STUDENT INFORMATION

STUDENT NAME _____

LAST *FIRST* *M.I.*

DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY NUMBER_____

FAMILY DOCTOR _____

_____

OFFICE *PHONE*

DENTIST _____

_____

OFFICE *PHONE*

EYE DOCTOR _____

_____

OFFICE *PHONE*

MEDICAL INSURANCE PLAN_____

POLICY NO_____

PLEASE ATTACH A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD

EMERGENCY CONTACT INFORMATION

_____

MOTHER/GAURDIAN NAME *PRIMARY PHONE* *ALT PHONE*

_____

FATHER/GAURDIAN NAME *PRIMARY PHONE* *ALT PHONE*

_____

NAME + RELATIONSHIP *PRIMARY PHONE* *ALT PHONE*

_____

NAME + RELATIONSHIP *PRIMARY PHONE* *ALT PHON*

MEDICAL INFORMATION

PLEASE NOTE ANY HEALTH PROBLEM, PHYSICAL HANDICAP, EMOTIONAL DIFFICULTY, BEHAVIORAL PROBLEM, OR FACTS WHICH MAY LIMIT FULL PARTICIPATION IN CLASSROOM ACTIVITIES:

_____

_____

_____

STUDENT'S IMMUNIZATION SHOTS ARE CURRENT (CIRCLE ONE): YES NO

PLEASE ATTACH A COPY OF YOUR STUDENT'S IMMUNIZATION RECORD

STUDENT IS SUBJECT TO/HAS (CIRCLE ALL THAT APPLY):

ASTHMA	EAR ACHES	NOSE BLEEDS	SENSITIVE SKIN
FAINTING	SINUS ISSUES	MOTION SICKNESS	EYE INFECTIONS
BRONCHITIS	CHRONIC COUGH	DIGESTIVE ISSUES	SEIZURES/EPILEPSY
ANXIETY/DEPRESSION	DIABETES	EYE PROBLEMS	THROAT INFECTIONS
BLOOD DISORDERS	EATING DISORDERS	HEADACHES	HEART MURMUR

OTHER_____

IF ANY OF THE ABOVE ARE CIRCLED, PLEASE EXPLAIN SITUATION AND IF CURRENT TREATMENT IS NEEDED (USE EXTRA PAPER AS NEEDED):_____

_____

_____

_____

PLEASE LIST ALL DRUG/FOOD ALLERGIES YOUR STUDENT HAS _____

_____

_____

ALLERGY TREATMENT PLAN_____

_____

_____

CURRENT MEDICATIONS_____

_____

_____

LIST AND GIVE DATES OF ANY SIGNIFICANT INJURIES/SURGERIES (IF "NONE" PLEASE INDICATE)_____

_____

_____

MEDICAL INFORMATION (CONTINUED)

STUDENT WEARS CONTACT LENSES/GLASSES (CIRCLE ONE): YES NO

IS THERE ANY OTHER INFORMATION WHICH WOULD BE HELPFUL TO HAVEN ACADEMY IN REGARDS TO YOUR STUDENT'S HEALTH PROFILE?_____

MAY THE MEDICAL SUPERVISOR ADMINISTER ANY OF THE FOLLOWING TO YOUR CHILD? (PLEASE CIRCLE ONE EACH)

SYMPTOMS	TREATMENTS		
CUTS/SCRATCHES	PEROXIDE/NEOSPORIN	YES	NO
FEVER/HEADACHE	ACETAMINOPHEN/IBUPROFEN	YES	NO
MENSTRUAL CRAMPS	ACETAMINOPHEN/IBUPROFEN	YES	NO

****

I GIVE MY PERMISSION FOR MY CHILD TO RECEIVE THE ABOVE MEDICATIONS AS INDICATED BY THE "YES" COLUMN.
BEFORE TREATMENT IS PROVIDED FOR ANY OTHER ILLNESS OR INJURY, PARENTAL CONTACT OR PHYSICIAN ADVICE WILL BE SOUGHT.

IN CASE OF MEDICAL EMERGENCY, I GIVE PERMISSION TO THE PHYSICIAN SELECTED BY HAVEN ACADEMY OF SALINA OR THEIR DESIGNEES TO SECURE PROPER TREATMENT FOR MY STUDENT.
EVERY EFFORT WILL BE MADE TO FIRST CONTACT PARENT OR GUARDIAN AND EMERGENCY CONTACTS PROVIDED VIA THE STUDENT MEDICAL FORM.

I AM THE PARENT/GUARDIAN OF THE CHILD NAMED ABOVE. I GIVE PERMISSION FOR THE INFORMATION OF THIS FORM PROVIDED ABOUT MY CHILD TO BE REVIEWED AND UTILIZED ONLY BY THE STAFF OF THIS SCHOOL AND ANY HEALTH SERVICES FOR THE LIMITED PURPOSE OF MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS.

_____
PRINTED PARENT/GUARDIAN NAME

_____
PARENT/GUARDIAN SIGNATURE

_____
DATE