2016 STUDENT MEDICAL INFORMATION

Student's Name:_____ Date of Birth _____ Gender _____

Please complete this form and return by June 3. Staple to this form copies of student's (or parent's) medical insurance card (both sides) and prescription card if applicable. This form does not require a physical examination. If necessary, please use the back of this form or a separate sheet to complete answers.

In case of medical treatment, who should be notified?
Name:_____ Relationship:_____

Daytime Telephone (_____)_____ Evening Telephone (____)_____

Does your student have a primary care/family physician? Yes No

Name:_____ Telephone (____)_____

Address _____
Street City/State Zip

Over-the-counter products (e.g., pain relievers, allergy medication/creams, throat lozenges, poison ivy lotions, etc.) may be made available to my child by a member of the Governor's School staff Yes No

1. Has your student had any serious illness, surgery, mental health diagnosis (including anorexia, bulimia, depression), or trauma? Yes No *Please include an explanation, dates of occurrence, and treatment.*

2. Does your student have any chronic conditions, disabilities, or requirements for assistive devices, including respiratory problems, diabetes, cardiac problems, bleeding disorders, and seizures? Yes No
If yes, please explain.

3. Does your child have any drug, food or environmental allergies? Yes No
If yes, please list all allergies and the treatment(s) your child is currently using.

4. Please list all medications that your child is currently taking, has taken in the past two months, or is required to take for any continuing medical problem; use the back of this form if necessary. Complete an "Authorization for Administering Prescription Medication" for each prescription to be taken during Governor's School

5. When was your student's last tetanus shot? _____ Required within past ten years.

6. Does your student wear contacts? Yes No

CONSENT FOR EMERGENCY TREATMENT

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Director to administer appropriate emergency treatment, to hospitalize, and/or to order injections/anesthesia/surgery for my child as named above.

_____
Name of Parent or Guardian (Please Print) Signature Date