College for Kids 2017

Student Health Record-<u>FILL OUT ONLY 1 PER STUDENT/ SUMMER</u>

Form A—<u>DOES NOT REQUIRE A DOCTOR'S SIGNATURE</u>

Westfield State University 577 Western Avenue Westfield MA 01086-1630

(413) 572-8557 Fax: (413) 572-5227

To be filled out by parent or guardian (please print):

Child's Name: _____ Age: _____ Date of Birth: _____

Home Address: _____ Phone: _____

City/State/Zip Code: _____

School: _____

Parent/Guardian Information:

Parent's Name(s)	Home Address	Home Phone	Work Address	Work Phone

If not available in an emergency notify:

1. _____
   Name Address Phone
2. _____
   Name Address Phone

MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO
Anemia			Gastro Intestinal problems			Surgery		
Asthma			Head Injury			Appendectomy		
Back Injury/Problem			Headaches (recurrent)			Tonsillectomy		
Blood Transfusion			Hearing Deficit			Thyroid Disease		
Chicken Pox			Heart Murmur			Urinary Tract Infection		
Contact Lenses			Hepatitis					
Depression/Anxiety			High Blood Pressure			OTHER:		
Diabetes			Kidney Problems					
Disease/Injury of Joints/Bones			Learning disability					
Ear, Nose, Throat Problems			Mononucleosis					
Eating Disorders			Rheumatic Fever					
Eye Problems			Seizures					
Fainting			Strep Throat					

Allergies: (please specify)_____

_____

Dietary Restrictions: (please specify) _____

Chronic or recurring illness/diability:_____

Medications: _____

Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:

_____

Are your child's immunizations up to date? _____ Yes _____ No

Name of dentist: _____ Phone: _____

Name of pediatrician: _____ Phone:_____

Do you carry family medical/hospital insurance? _____ If so, indicate:

Carrier: _____ Policy/Group #: _____

Any specific activities to be encouraged? _____

Any specific activities to be discouraged? _____

<u>IMPORTANT</u>: ***PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.***

Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.

Parent's Signature: _____ Date: _____