RETURNING STUDENTS

MEDICAL INFORMATION FORM

2009-10

Woodberry Forest School, Woodberry Forest, Virginia 22989

This completed form must be on file before the student will be registered.

■ Part I: MUST BE COMPLETED BY PARENTS OR GUARDIANS. *Please type or print plainly.*

Student's name
Last name *First name* *Middle name* *Name called*

Birth date ⇨ Social Security Number |___|___|___|-|___|___|-|___|___|___|___|

Home address
Street *City* *State* *Zip*

Home phone

Student resides with ❑ both parents ❑ father ❑ mother

Father/guardian's name
Last name *First name* *Middle initial*

Employer/occupation
Business phone *Cell phone* *email*

Mother/guardian's name
Last name *First name* *Middle initial*

Employer/occupation
Business phone *Cell phone* *email*

*In Case of Emergency** Relationship
***must be someone other than parents** *Last name* *First name* *Middle initial*

Home phone *Business phone* *Cell phone* *email*

⇨ Medical Insurance Information. *Legible copy of front and back of insurance card* MUST *be attached.*

Policyholder's name Policyholder's Social Security No.

Insurance company name Policy No. Group No.

Street *City* *State* *Zip*

Medical History. Circle the appropriate answers and provide details below where applicable.

Allergy
- Drug . . . . . YES. . .NO
- Food . . . . . YES. . .NO
- Insect bite . . . . . YES. . .NO
- Other . . . . . YES. . .NO

Asthma . . . . . YES. . .NO
Bed-wetting . . . . . YES. . .NO
Bronchitis . . . . . YES. . .NO
Defects, congenital . . . . . YES. . .NO
Defects
- Central nervous system . . . YES. . .NO

Gastrointestinal . . . . . YES. . .NO
Hearing . . . . . YES. . .NO
Heart . . . . . YES. . .NO
Musculoskeletal . . . . . YES. . .NO
Urinary tract . . . . . YES. . .NO
Eye, serious . . . . . YES. . .NO
Depression. . . . . YES. . .NO
Diabetes . . . . . YES. . .NO
Ear infections, frequent . . . . . YES. . .NO
Eczema . . . . . YES. . .NO
Emotional problems . . . . . YES. . .NO

Fainting . . . . . YES. . .NO
Glasses/contact lenses . . . . . YES. . .NO
Hives . . . . . YES. . .NO
Migraine headaches . . . . . YES. . .NO
Mononucleosis . . . . . YES. . .NO
Pneumonia . . . . . YES. . .NO
Psychological problems . . . . . YES. . .NO
Rheumatic fever . . . . . YES. . .NO
Sinusitis . . . . . YES. . .NO
Seizures . . . . . YES. . .NO
Sleepwalking . . . . . YES. . .NO

Sore throats, frequent . . . . . YES. . .NO
Recent illness lasting more than a week . . . . . YES. . .NO
Recent injuries requiring medical attention . . . . . YES. . .NO
Surgical operations . . . . . YES. . .NO
Currently taking medication . . YES. . .NO
Date of last tetanus booster: ___/___/___

Give details of "Yes" answers and a brief history of your child's overall health. Please list all medications he is currently taking.

TREATMENT AUTHORIZATION

I authorize the school physician, school nurse, or other health professional to render necessary medical care to my child/ward named above. I understand that this authorization does not include medical care beyond that which is usual and customary for routine or emergency treatment.

However, in the event of an emergency, and if I am unable to be reached by the School, hospital, nurse, or physician, as the case may be, I consent for the School to act on my behalf in granting permission for medical treatment, including surgery requiring the use of an anesthetic. This authorization shall be in effect as long as my child is a student at Woodberry Forest School.

I give Woodberry Forest School my consent to administer any incomplete immunizations, lab tests, or physical exams needed for my child's attendance at the School. I understand I will be charged for these services.

I give permission to release medical information regarding my child to the faculty and/or administration at Woodberry Forest School and other health care providers as necessary. This information will be released on a need-to-know basis and will be kept confidential by those persons.

⇨ Date ⇨ Parent or guardian signature

■ **Part II: To be completed by physician.** *Please respond to every line.*

Height _____ Weight _____

Blood Pressure: _____ / _____ Pulse _____

Eyes: R 20/ _____ L 20/ _____ Pupils equal Yes No

Ears _____ Hearing R+ L+

Nose _____

Mouth _____

Throat _____

Skin _____

Lymph nodes _____

Heart _____

Lungs _____

Abdomen: _____

Liver _____

Spleen _____

Hernia _____

Genitalia _____

Neurologic _____

Musculoskeletal: _____

Scoliosis _____

General assessment of muscular strength and flexibility _____

Laboratory tests and immunization information:

Urinalysis (required yearly) _____

PPD **(required for every student the first time he attends Woodberry Forest, and then if indicated)** _____

Date: ____/_____ Result: _____
month/year

PHYSICIAN'S STATEMENT

I certify that I have on this date examined this student and find him physically able to compete in supervised activities such as:

Baseball	Kayaking	Squash	Weightlifting
Basketball	Lacrosse	Swimming	Wrestling
Cross country	Racquetball	Tennis	
Football	Rock climbing	Track	
Golf	Soccer	Volleyball	

Comments _____

Date _____ Signed _____
Physician

Physician's name, address, and telephone number (please print): _____