STRAFFORD SCHOOL HEALTH SERVICES
Medical Information

Student's Name: _____ DOB:_____ Home Telephone: _____
Full Address: _____
Parent/Guardian: _____
Primary Physician: _____ Phone: _____
Primary Dentist : _____ Phone: _____

History:

_____ Chicken Pox	____ Lung Disease	____ Kidney Disorders	____ Diabetes	____ Balance Problem
_____ Heart Disease	____ Seizures	____ GI Issues	____ Head Injury	____ Fainting Spells
_____ Dev. Disability	____ Asthma	____ Blood Disorder	____ Stomach Issue	____ OTHER

Dates/Explain :_____
_____
_____
_____

ALL Current Medications: _____ for _____
_____ for _____
_____ for _____
_____ for _____

Allergies: ***Medications*** _____
Foods _____
Environmental _____

Dietary Restrictions: _____

Exam:

Height _____ Weight _____ Vision: _____ Hearing: _____

_____ ENT	_____ Neck	_____ Abdomen	_____ Joints/ROM
_____ Teeth/Gums	_____ Chest	_____ Spine	_____ Skin
_____ Thyroid	_____ Heart	_____ CNS	_____ Genitalia
_____ Lymph Nodes	_____ Lungs	_____ Orthopedic	

Explain:_____
_____
_____

Sensory, Physical or cognitive disabilities? Y N Explain: _____
Mobility Impairments ? Y N Explain: _____

Are there any health concerns that the camp/school personnel should be made aware of? _____
_____
_____

This child's physical condition allows for:
_____ FULL participation in all physical activities
_____ NO participation in any physical activities
_____ LIMITED participation in all physical activities

Explain rest./limitations :_____
_____

Physician's signature:_____ EXAM Date: _____
Printed name of physician: _____ TODAYS Date: _____
Address: _____

***PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD**

STUDENT'S HEALTH HISTORY

(To be completed by a parent/guardian)

Dear Parent:
We would like your child to gain the most from this experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please make sure **both sides of this form are completed, a physician's signature IS required.**, Return A.S.A.P.

Kathryn Cunningham RN

STUDENT:_____ **M / F** D.O.B. : _____

EMERGENCY CONTACT INFO:

Name : _____ Relationship : _____
Phone : (H): _____ (W): _____ Cell: _____
Name : _____ Relationship : _____
Phone : (H): _____ (W): _____ Cell: _____

Insurance Co. : _____ Phone: _____
Employer : _____ Policy #: _____
Employee (carrier): _____ Group #: _____
Family Physician : _____ Phone : _____
Primary Dentist : _____ Phone: _____

		YES	NO
Has your child ever had an illness or injury that:	a) required him/her seek medical attention?	____	____
	b) lasted longer than a week?	____	____
	c) required hospitalization or an operation?	____	____
	d) is chronic? (i.e. Asthma, Diabetes, etc)	____	____
	e) required x-rays ?	____	____
Has your child had surgery or been hospitalized within this past year?		____	____
Has your child ever had any heart-related abnormality?		____	____
Has your child ever: a) been dizzy or passed out during or after exercise?		____	____
b) been unconscious or had a concussion?		____	____
c) had a seizure?		____	____
Does your child wear glasses or contact lenses?		____	____
Does your child wear braces, bridges, or dental plates?		____	____

Please explain any 'YES' answers. _____

_____

_____

List all medications your child will be **taking during this trip** and what the medication is for.

a) _____ for _____Dose_____ When_____
b) _____ for _____Dose_____ When_____
c) _____ for _____Dose_____ When_____
d) _____ for _____ Dose_____ When_____

*********** ALL MEDICATIONS, non-prescription and prescription, must be in CURRENT ORIGINAL containers. Prescribed medications must have current Pharmacy label with directions stated. In accordance to the Strafford School Medication Administration Policy #JLCD, All medications MUST BE delivered to the school by a parent or guardian. All Prescription medications must also have a written order from the Physician. An administration authorization must also be signed at that time.**

* I consent to and authorize emergency and non-emergency medical care to be provided to my child, in the event of any illness or injury while in the care of Strafford School's personnel, during this trip. I understand that every attempt will be made to contact me in the event that medical care is needed, and that I am responsible for all medical costs incurred in treating my child.

_____ _____
Parent/Guardian Signature Date