



MEDICAL INFORMATION

Name _____ Sex _____ Birthdate _____
Age _____ Current Grade _____ Social Security Number _____
Father _____ Work Phone (_____) _____
Address _____ Home Phone (_____) _____
City _____ State _____ Zip _____ Cell Phone (_____) _____
Mother _____ Work Phone (_____) _____
Address _____ Home Phone (_____) _____
City _____ State _____ Zip _____ Cell Phone (_____) _____
Personal Physician _____ Telephone (_____) _____
Personal Dentist _____ Telephone (_____) _____
Student resides with: Both Parents _____ Father _____ Mother _____ Other _____
Parents' Email _____ Fax _____

I. Check (X) if student has **had** any of the following. Please explain any (X) answers on the back.

_____ Operations	_____ Malaria
_____ Physical handicap	_____ Kidney Disease
_____ Concussion or head injury	_____ Fractures
_____ Tuberculosis	_____ Whooping Cough
_____ Scarlet Fever	_____ Chicken Pox

II. Check (X) if student has any of the following. Please explain any (X) answers on the back.

_____ Asthma	_____ Abdominal pains
_____ Hay Fever	_____ Constipation
_____ Allergies - to what	_____ Menstrual problems
_____ Ear trouble	_____ Hernia
_____ Hearing loss or defect	_____ Heart trouble
_____ Glasses/Contact Lenses	_____ Epilepsy
_____ Tonsilitis	_____ Diabetes
_____ Indigestion	_____ Emotional problems

III. Is there any other medical information which you feel we should have about this student? Is the student on any medications? Please specify.

IV. Date of last tetanus shot _____

V. Family History - Briefly explain any family history (including parents, grandparents, uncles, aunts, brothers and sisters) of the following:

1. Allergies _____
2. Diabetes _____
3. Cardiac Problems _____
4. Other _____

VI. Current insurance information. If none, write "NONE".

A. Insurance Company _____

B. Insurance Address _____ City _____ State _____ Zip _____

C. Policy Number _____

D. Subscriber _____

E. Employer _____

F. Employer Address _____ City _____ State _____ Zip _____

G. Notification Required _____ Yes _____ No If yes, telephone # _____

VII. Authorizations

A. The Academy is authorized carry out accepted health procedures for my child and act in my behalf for medical or surgical services deemed necessary to protect the welfare of the same. I give permission for information to be released, if necessary, regarding my child's health situation to administrative authorities, appropriate staff and faculty, health care providers and institutions, pharmacies, and my health insurance company.

B. The Academy is authorized to administer prescription and non-prescription medications as needed to my child.

C. Financial Responsibility

When not covered or paid through medical insurance coverage, I accept full responsibility for all medical expenses including doctors' fees, lab fees, hospital fees, and medicines while my child is in attendance at Dublin Christian Academy.

D. The following people may be notified in case of emergency and given appropriate information regarding my child's health situation.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

E. Release of information may be done using fax, e-mail, telephone, postal service, or in person.

I hereby agree to all of the above authorizations.

Signature of Parent or Guardian _____ Date _____

Student (over age 18) _____ Date _____

A copy of these signatures is as valid as the original.

Explanations from Side #1