

Student Health Form



To register, fill out all information, sign and return/mail with the Student Enrollment Application.
PLEASE WRITE CLEARLY (To be completed by parent/guardian)

STUDENT INFORMATION

Name:	Sex: MALE	Age:	Date of Birth: m d y
Street Address:	City:	State:	Zip:
In emergency, G-d forbid, notify:	Relationship:		
Address:	Home Phone:		
Work:	Cell:	Beeper:	

GENERAL HEALTH RECORD

Height:	Weight:	Date of Exam:
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Identify any known medical or emotional illness or disorder that would currently pose a risk to other students or which currently affects your son's functional ability to participate safely:

Medical information pertinent to routine care and emergencies:

Is your son taking prescription medication for an illness/condition? YES NO

If YES Please fill out the Authorization to Administer Medication form

Does your son have allergies? YES NO Explain:

Is your son on a special diet? YES NO Explain:

Is your son current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health? YES NO

Does your son wet the bed? YES NO

The above named person is in satisfactory condition and may engage in all school activities except as noted:

INSURANCE INFORMATION

Medical Insurance Company:	Policy Number:
Name of Policy Holder:	

Please send copy of card

MEDICAL AFFIRMATION

Signature of M.D., APRN, LPN or PA or Parent:

Date: m d y	State Licensed in:	Lic. #
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Address:

AUTHORIZATION

PARENT OR GUARDIAN AUTHORIZATION (REQUIRED FOR ALL PERSONS UNDER 18)
This health history is correct so far as I know, and the person named above has permission to participate in all school activities except as noted by the examining physician or me. If I can not be reached in an emergency, I hereby give permission to the physician selected by the school principal or his designated authorized person to hospitalize, secure proper treatment for and order injection, anesthesia for surgery for the person named above.

Parent or Guardians Signature Date: m d y

Medical Authorization Form



If needed, fill out all information, sign and return/mail with the Student Health Form.
PLEASE WRITE CLEARLY (To be completed by parent/guardian)

STUDENT INFORMATION

Name of Student: _____ Age: _____
Food/Drug Allergies: _____
Diagnosis (at parents discretion): _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ Home Telephone: _____
Business Telephone: _____ Emergency Telephone: _____

DOCTOR INFORMATION

Name of Licensed Prescriber: _____
Business Telephone: _____ Emergency Telephone: _____

MEDICATION INFORMATION

Name of Medication: _____ Dose given at school: _____
Route of Administration: (oral, etc.) _____ Frequency: _____
Date Ordered: *m d y* _____ Duration of Order: _____ Quantity Received: _____
Expiration date of Medications Received: *m d y* _____ Special Storage Requirements: _____
Specific Directions: Take on empty/full stomach with water etc.): _____
Specific Precautions: _____
Possible Side Effects/Adverse Reactions: _____
Other medications (at parents' discretion): _____
Location where medication administration will occur: _____

AUTHORIZATION

I hereby authorize Mesivta Menachem to administer, to my child, _____ the medication(s) listed above



Parent or Guardians Signature _____ Date: *m d y* _____