

STUDENT HEALTH RECORD 2012

This document must be completed and filed with the DUCA Office by **May 31, 2012**
 Please send to: Drexel University – TheiSchool at Drexel, Attn: DUCA, 3141 Chestnut St., Philadelphia, PA 19104

A parent or legal guardian must sign the Authorization for Emergency Medical Attention, Part III (below).

PART I: STUDENT INFORMATION (Print or type all information)

Student's Full Name: _____ Date of Birth ___ / ___ / ___ Gender: Male Female
 Permanent Home Address: _____ Student Social Security # _____ - _____ - _____
 _____ Home Telephone # (____) _____ - _____
 _____ Parent(s)' Work Phone(s) (____) _____ - _____
 _____ (____) _____ - _____

PART II: INSURANCE COVERAGE INFORMATION

| | | |
|-------------------------|--|--|
| Please Check One | <input type="checkbox"/> Student is covered under family policy. <input type="checkbox"/> Student is covered by an individual policy <input type="checkbox"/> Student is covered by public assistance. <input type="checkbox"/> Student is <u>not covered</u> by insurance/ public assistance. <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Our insurance coverage requires authorization for treatment. Call _____ at _____ _____ before proceeding. TERMS OF AUTHORIZATION: _____ |
|-------------------------|--|--|

Primary Care Physician's telephone # and address if required for health care
 (____) _____ - _____

| | |
|---|---|
| Attach Photocopy of <u>front</u> of PRIMARY Insurance Card to this area. | Attach Photocopy of <u>front</u> of SECONDARY Insurance Card to this area. |
| Attach Photocopy of <u>back</u> of PRIMARY Insurance Card to this area. | Attach photocopy of <u>back</u> of SECONDARY Insurance Card to this area. |

Please complete the following, even if information is indicated on insurance card:
 Name of Policy Holder _____ Student's Relationship to Policy Holder _____
 Social Security # of Policy Holder _____ Plan # _____ Policy # _____
 Name and **Billing** Address of Insurance Company _____
 Telephone # of Insurance Company (____) _____ Policy Expiration Date _____

PART III: AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION AND STATEMENT OF RESPONSIBILITIES

- *In the event of an emergency or an occasion requiring immediate health care treatment, I hereby authorize you to proceed in accordance with good medical practice in the treatment of my child.*
- *I authorize the caregiver to release pertinent information to the insurance company.*
- *I assume full financial responsibility of costs related to treatment which are not covered by insurance.*

Parent or Guardian's Signature _____ Date _____
 Emergency Telephone Number(s) _____

Please turn over and complete parts IV - VIII

PART IV: PHYSICIAN'S STATEMENT

Student's Name: _____

I certify that I have examined the student and believe that he/she is physically qualified to participate in an intense, five-week, residential program that includes a full schedule of classes and a recreational program, and one which does not allow for visits home. The information provided below and on the reverse of this page is current as of today's date.

Physician's Signature: _____ Date: _____

Please print: Physician's Name: _____ Office Telephone #: (____) ____ - _____

Physician's Office Address: _____ City: _____ Zip: _____

PART V: IMMUNIZATION HISTORY

Please enter Month/ Date/ Year of each immunization/ inoculation. The most recent immunization for tetanus must be dated after July 31, 1995. It is Pennsylvania school law that a student has one immunization for MMR after one year of age. It is recommended that a booster be given at age eleven or twelve.

| | | | | | | | |
|---------|-------|------------|-------|-----------------|-------|---------------|-------|
| MMR | _____ | Pertussis | _____ | Mantoux TB Test | _____ | Poliomyelitis | _____ |
| Tetanus | _____ | Diphtheria | _____ | Typhoid | _____ | Meningitis | _____ |

PART VI: MEDICAL HISTORY

A. History of communicable diseases: No Yes If yes, please explain: _____

B. History of serious illness or operations: No Yes If yes, please explain: _____

C. History of treatment for substance abuse or emotional problems: No Yes If yes, please explain: _____

D. History of physical injury (past 18 months): No Yes If yes, please explain: _____

E. Physical Examination:

| | | | | | | |
|-----------------|-------|-----------------------|-------|----------------------|-----------------------------|------------------------------|
| Height (inches) | _____ | Weight | _____ | Normal: | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart | _____ | Blood Pressure/ Pulse | _____ | Lungs | _____ | _____ |
| Eyes/ Vision | _____ | Ears/ Hearing | _____ | Nose/ Sinuses | _____ | _____ |
| Throat | _____ | Glands | _____ | Viscera | _____ | _____ |
| Genitalia | _____ | Skeleton | _____ | Neuromuscular System | _____ | _____ |

Please annotate any abnormalities noted above. _____

PART VII: ALLERGIES/CHRONIC CONDITIONS/DIETARY RESTRICTIONS

A. History of allergies or sensitivity to medicines. No Yes If yes, please explain: _____

B. History of allergies or chronic conditions. No Yes If yes, please explain: _____

C. Dietary restrictions: No Yes If yes, please explain: _____

PART VIII: MEDICATIONS

A. This student is required to take medication: No Yes If yes, please complete the following:
The school nurse will determine which medicines the student may keep and which will be stored in the infirmary.

B. Over-the-counter medication(s) to be self-administered by student:

| If yes, Condition | Medication | Dosage | Strength | Directions for Use |
|-------------------|------------|--------|----------|--------------------|
| | | | | |
| | | | | |

C. Prescription medication(s) to be self-administered by student:

| If yes, Condition | Medication | Dosage | Strength | Directions for Use |
|-------------------|------------|--------|----------|--------------------|
| | | | | |
| | | | | |

D. Medications to be administered by the school nurse:

| If yes, Condition | Medication | Dosage | Strength | Directions for Use |
|-------------------|------------|--------|----------|--------------------|
| | | | | |
| | | | | |

If more space is needed, please attach additional pages.