

STUDENT HEALTH RECORD 2010

This document must be completed and filed with the DUCA Office by **MARCH 1, 2010**.

Please send to: College of IST, DUCA c/o: Miguel Vargas, 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"/> Our insurance coverage requires authorization for treatment. Call _____ at _____ _____ before proceeding. <p style="text-align: center;">TERMS OF AUTHORIZATION:</p> _____
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Primary Care Physician's telephone # and address if required for health care
 (____) _____ - _____ _____

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

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.