Greensprings School

MEDICAL HISTORY FORM

Please PRINT all information.

Student_____ Date of Birth_____
surname first middle

Complete Address_____

_____

Student resides with ___ both parents ___ father ___ mother ___ other (specify)

Father _____ surname first middle Phone _____ home mobile Guardian _____ surname first middle Phone _____ home mobile	Mother _____ surname first middle Phone _____ home mobile Emergency Contact _____ surname first / middle Phone _____ home mobile

AUTHORIZATION FOR TREATMENT

If the above-named student should become ill or sustain an injury while attending Greensprings School, immediate attention may be necessary. In order to eliminate potentially harmful delay in treatment if it is not possible to reach parent(s) or guardian for permission to give the student appropriate treatment, we ask that the responsible adult signs the statement below.

I hereby authorize Greensprings School (or their designee) to administer to _____whatever medication, medical or surgical treatment deemed necessary or advisable by them in case of emergency.

Signature _____ Relationship_____ Date _____
(Parent or legal guardian)

EMERGENCY INFORMATION

List all allergies (drug, environmental, insect, food) _____

_____Most recent tetanus booster _____

Applicable Medical History (asthma, diabetes etc.)_____

Current Medications _____ Surgical History _____

_____

- **Please submit these forms along with a copy of the student's immunization record.**

STUDENT'S NAME_____

PHYSICAL EXAMINATION (This page must be completed by the student's PHYSICIAN) PLEASE READ CAREFULLY AND PROVIDE ***ALL*** REQUESTED INFORMATION.

Height _____ Weight _____ Blood Pressure_____

Urinalysis: Routine _____ Microscopic _____

	Yes	No		Yes	No
Allergies			Joint problems		
Heart disease / murmur			Foot problems		
High blood pressure			Gastro intestinal problems		
Anaemia			Eating disorders		
Chronic cough			Recent weight change		
Chronic sinusitis			Kidney stones		
Eye problems			Chronic urinary tract infection		
Ear / nose / throat problems			Menstrual problems / abnormalities		
Gum / tooth problems			Depression / anxiety		
Recurrent headaches			Attention Deficit Disorder		
Dizziness / fainting spells			Other emotional disorders		
Head injury with LOC			Insomnia		
Seizure disorder			Tuberculosis		

- Please use an extra sheet to detail 'yes' answers.

Other medical problems

_____

Surgical History

_____

Wears eye glasses _____yes _____no

Hearing screening: **Right ear** ____normal ____impaired **Left ear** ____normal ____impaired

Physical examination within normal limits? yes____ no____

Current medications: Greensprings School requires that all prescription medications be made known to the Clinic staff. All medications must be given to the School Nurse and dispensed from the Clinic on a daily basis, according to the prescription.

PLEASE LIST COMPLETE INFORMATION ON **ANY** AND **ALL** MEDICATIONS.

Daily medications:_____

As-needed medications:_____

Physician's signature_____ Date _____

Physician's address_____

_____Phone_____