

## STUDENT MEDICAL INFORMATION

Parents, please type or print to complete **both sides** of this form. Attach additional sheet(s) and "Authorization for Administering Prescription Medication Form" if necessary. **Staple to this form** photocopies of your student's medical insurance card (all sides), prescription card (all sides), and driver's license or other photo identification (e.g. school ID). This form does **not** require a physical examination. Please mail this form immediately and no later than **May 18**.

**NOTE: The Department of Education has ruled that failure to disclose health information may result in your child's dismissal. Please note that this disclosure does not impact your child's ability to participate in the program in any way. The information you provide will remain confidential.**

## GENERAL INFORMATION

### Student information:

Name \_\_\_\_\_ Nickname: \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

### In case of medical treatment, who should be notified?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Daytime (\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_ Wireless: (\_\_\_\_) \_\_\_\_\_

### Emergency contact other than parent (or other parent if separated):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Daytime (\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_ Wireless: (\_\_\_\_) \_\_\_\_\_

### Does your child have a primary care/family physician? Yes No

Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

## INSURANCE AND BILLING INFORMATION

### Name of person responsible for bill:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Telephone (\_\_\_\_) \_\_\_\_\_ Evening Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

### Do you have medical insurance coverage for your child? Yes No

Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Pre-Authorization Telephone\* (\_\_\_\_) \_\_\_\_\_ Co-Pay Amount \$ \_\_\_\_\_

Owner of Policy \_\_\_\_\_ Relationship \_\_\_\_\_

Policy \_\_\_\_\_  
ID NUMBER GROUP NUMBER SSN

\* If your insurance requires pre-authorization for treatment, Governor's School personnel will use this number to contact your insurer.

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### MEDICAL HISTORY

1. Has your child had any serious illness, surgery, mental health diagnosis (including anorexia, bulimia, or depression), or trauma?  Yes  No *Please include an explanation, dates of occurrence, and treatment.*
  
2. Does your child have any chronic conditions, disabilities, or requirements for assistive devices?  
 Yes  No *If yes, please explain.*
  
3. Does your child have any drug, food, or environmental allergies?  
 Yes  No *If yes, please list all allergies and the treatment(s) your child is currently using.*
  
4. When was your child's last tetanus shot? \_\_\_\_\_ *(Suggested within the last 10 years)*

### MEDICATION

Note: Students are responsible for all medication (prescription and over-the-counter) they bring with them to Governor's School, and they may not distribute medications to fellow students.

1. Please list all medications that your child is currently taking, has taken in the past 2 months, or is required to take for any continuing medical problem. Complete an "Authorization for Administering Prescription Medication" for **each prescribed medication** to be taken **during** Governor's School; this form is not necessary for over-the-counter medication.
  
2. Over-the-counter products for routine minor ailments (*e.g.*, pain relievers, allergy medication/creams, and throat lozenges) may be made available to my child by a member of the Governor's School staff.  
 Yes  No

### CONSENT FOR TREATMENT

*In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Director to administer appropriate emergency treatment, to hospitalize, and/or to order injections/anesthesia/surgery for my child as named above. Furthermore, I understand I am financially responsible for charges incurred and authorize the physician to release information requested by the insurance company.*

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
NAME OF PARENT OR LEGAL GUARDIAN (PLEASE PRINT)

\_\_\_\_\_  
DATE