



SAINT HERMAN OF ALASKA Christian School

an Eastern Orthodox Parish School of the Holy Resurrection Orthodox Church

Student Health Form (To Be Signed by A Physician)

The information requested on this form is necessary for the school health record for your child. The permission form is essential if you wish us to respond to medical problems on your child's behalf. This information is strictly confidential and is restricted to school staff.

Name: _____ Age: _____ Birth Date: _____

Address: _____

Home phone: _____ Home email address: _____

Father's Name: _____ Work phone: _____ Cell: _____

Mother's Name: _____ Work phone: _____ Cell: _____

In case of serious illness or injury at school and parent(s) cannot be reached, whom should we call?

Child's doctor: _____ Phone: _____

Other responsible adult: _____ Relationship: _____

Phone numbers where this individual can be reached: _____ / _____

Health Insurance: _____

Group or I.D. No.: _____

Please explain in full if there is a specific procedure required by your health insurer/HMO in order for your child to receive urgent care treatment. For example, must a primary care physician (PCP) be notified to authorize emergency care; are there specific hospitals that must be utilized to comply with your plan?

I hereby grant permission for my child, _____, to be given appropriate medical care in case of emergency. I will assume responsibility for payment of physician's or hospital care which is not covered by my insurance or medical plan. I understand that the school staff will make every effort to contact a parent, family doctor or responsible adult as listed above in an emergency situation.

Parent's signature: _____ Date: _____

Student name _____

Medical Profile

This portion of the health form must be completed by the child's physician.

Does this child have any allergies (food, medications, bees/insects, other)? ____ If so, please describe reactions and treatment.

Is this child presently under medical or psychiatric treatment? ____ Please explain how or if this might impact the child's participation in school activities.

Does this child wear glasses or contacts? ____ If so, at all times or just during certain activities (i.e. reading)?

Does this child have any other existing conditions at present (recurring headaches, nosebleeds, behavioral problems, etc.) which might occur at school? Please explain how we could best minister to the child in these situations. (Attach additional sheet if necessary.)

Date of most recent physical exam: _____ Weight: _____ Height: _____

Medical History (note age at onset):

Asthma _____ Heart Disease _____ Pneumonia _____
Chicken Pox _____ Measles (type) _____
Rheumatic Fever _____ Convulsions _____ Scarlet Fever _____
Diabetes _____ Whooping Cough _____ Diphtheria _____ Mumps _____
Discharging Ears _____ Polio _____

Other conditions _____

Previous surgeries or hospitalizations: _____

Student name _____

In compliance with the Department of Public Health Law of the Commonwealth of Massachusetts, it is required of all private and public schools to have a record of the immunizations of each student enrolled.

Immunizations (enter dates administered)

DPT/DT/TT (dates): 1. _____ 2. _____ 3. _____ 4. _____ 5.

Polio: _____ 1. _____ 2. _____ 3. _____ Booster _____

Tetanus: 1. _____ Booster _____

Varicella: _____ 1. _____ 2. _____ MMR: 1. _____ 2. _____

HIB: _____ 1. _____ 2. _____ 3. _____ 4. _____

Other:

Hep B: 1. _____ 2. _____ 3. _____

Non-immunization waiver attached

TB status: _____ (optional) Lead screening: _____

Any restrictions for physical activities? _____

By law, the school is only permitted to dispense prescription or over-the-counter medications by a school nurse with the approval of the child's physician. Please note here the name, dosage, and purpose of any medications which this child may require:

Physician's signature: _____ Date: _____

Physician's name (print/type/stamp): _____

Address: _____ Phone: _____

All of the above information is accurate to the best of my knowledge.

Signature of Parent: _____ Date: _____