

16. Health Information Form
(front and back)

Student Name: _____
 Student Date of Birth: _____
 Address: _____
 Home Phone Number: _____
 Previous School: _____
 Legal Guardians: (Check One) Both Parents Mother Father Guardian
 Name(s) of Guardians: _____
 Guardian's Home Phone: _____
 Guardian's Work Phone: _____
 Guardian's Cell/Pager: _____
 In emergency, notify: (Name) _____
 In emergency, call phone #s: _____
 Doctor's Name/Health Center: _____
 Doctor's Phone Number: _____
 Doctor's Fax Number: _____
 Preferred Hospital: _____
 Name of Health Insurance: _____
 Health Insurance Policy #: _____
 Name of Dentist: _____
 Allergies to Medication: _____
 Allergies to Food: _____

1. Do any of the student's family/household members have any major health problems?

Yes No If yes, please describe: _____

2. Has the student had any of the following illnesses or conditions?

Accidents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G6PD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lead Poisoning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Behavioral Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Menstrual Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney/Urinary Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Learning Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear/Throat Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospitalizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone/Joint Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please describe in more detail, any of the above items that are marked 'Yes:'

3. Hearing / Vision / Speech

Has this student had convulsions or seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this student had a hearing test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student have a hearing problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student have a vision problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this student had a vision test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student wear glasses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes: ___ Full Time ___ Reading ___ Distance ___ Other		
Does this student receive preferential seating for a vision/hearing problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this student receive speech therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please describe in more detail, any of the above items marked 'Yes:'

4. Does this student have any special needs that the School Health Program should be aware of?
(For example, is it necessary to limit activity?)

5. Is this student taking any medication on a daily basis? Yes No
If yes, please specify:

6. Has the student had Chicken Pox Disease? Yes No
If yes, date of disease: _____

If yes, a physician certified history must be on file at the school by August 2nd, 2010.

15. Physician and Parent/Guardian Authorization to Dispense Medication

Section to be completed by licensed prescriber.

Student Name _____ Parent Name _____
 Physician Name _____ Physician Phone _____
 Name of Medication _____ Route _____
 Dosage _____ Frequency/Administration Time _____
 Other Directions _____
 Date of Order _____ Discontinuation Date _____
 Diagnosis _____ Possible Side Effects _____
 Signature of Physician/Licensed Prescriber _____
 Date _____

Section to be completed by parent/guardian.

Student Name _____ Date of Birth _____
 Parent(s)/Guardian(s) Name _____
 Parent(s)/Guardian(s) Home Phone _____
 Parent(s)/Guardian(s) Work Phone _____
 Parent(s)/Guardian(s) Cell Phone/Pager _____
 Name of Medication _____
 Student's Food or Drug Allergies _____

I give permission to the school to administrate my student's medication, to share information relevant to the prescribed medication, to determine if self-administration of medication is safe and appropriate for my student's health, and to allow self-administration of medication. I hereby release Brooklyn Prospect Charter School, its staff members, and its officers from any liability associated with administration of my student's medication. I understand that medication may be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the school year.

Parent/Guardian Name

Parent/Guardian Signature

Date

