Houghton Academy

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Email: admissions@houghton.academy
Website: www.houghtonacademy.org

MEDICAL INFORMATION FORM **Please print or type.**

First Name | Middle Name | Family Name | Date of Birth (Mo/Day/Year) _____ Male ____ Female

Home Address | Home Address (continued)

City | State/Province | Country | Zip/Postal Code

In Case of Emergency

1) I give authorization for Houghton Academy staff or host family parent (for boarding students) to make decisions regarding medical/surgical care in event of an emergency or acute illness when a parent or guardian is not immediately available for a quick and urgent decision.

2) I give authorization for the exchange of pertinent medical/surgical information between Houghton Academy staff, including the school nurse, the school physicians, and any other medical personnel involved in the care and treatment of the student.

3) I give authorization for Houghton Academy to obtain copies of medical records, including mental health records, from a hospital, outpatient department or doctor's office when they are pertinent to the continuing care of the student and thus need to be in the school record.

This authorization covers any dates in which the student is enrolled at Houghton Academy. I hereby sign consent to all the provisions above:

Applicant (if 18 years of age over) | Date

Parent/Guardian (signature required if applicant is under 18 years of age) | Date

Emergency Contact Information

Parent or Legal Guardian

Home Address

City | State/Province | Country | Zip/Postal Code

Home Telephone (include ALL country, city, and area codes) | Work Telephone (include ALL country, city, and area codes)

Parent's Mobile Phone Number (include ALL country, city, and area codes) | Parent's E-Mail Address

Alternate Emergency Contact Person (someone Houghton Academy may contact if the parent cannot be reached)

Alternate Daytime Emergency Phone Number (include ALL country, city, and area codes)

US Health Insurance Information (if applicable)

ALL LINES MUST BE FILLED IN. Please provide a photocopy of the front and back of your insurance card. Boarding students should also provide a copy of prescription card.

_____
Name of Plan

_____
Policy/ID Number Group Number

_____
Subscriber

_____
Insurance Company

_____
Insurance Company Address

_____
Insurance Company Phone Number (include area code)

Does your insurance carry a deductible? ____ Yes (Deductible $_____) _____ No
Any charges for co-pays or deductibles will be added to the student's Academy account unless you advise your child to pay for them on the date of service.

Is prior approval required for treatment? ____Yes ____ No

If yes, give phone number for emergencies: _____

Health Insurance Information for Boarding Students

All students without US-based health insurance will be enrolled in a comprehensive accident and sickness health insurance policy. The cost of this coverage has been included in fees. Policy details are available from the medical office.

THIS FORM MUST BE COMPLETED AND RETURNED PRIOR TO ENROLLMENT.

Name of Student _____ Date of Birth _____

This page may be completed by a parent or a physician.

Medical History

Has the student had any of these conditions, diseases or injuries? If yes, give date(s).

NO	YES(DATE)			NO	YES(DATE)	
		Epilepsy				Severe Acne
		Diabetes				Headaches
		Concussion or Head Injuries				Nosebleeds
		Rheumatic Fever or Heart Disease				Chronic sinus trouble
		Eating Disorder (anorexia/bulimia)				Impaired hearing
		Hepatitis				Dizziness
		Malaria**				Cancer
		Chronic or frequent cough				Fractures or broken bones
		Asthma				Which bones/dates:
		Fainting				
		Strokes				
		Tuberculosis				Glasses/Contacts (Bring extra glasses/contacts)
		Spitting up blood				

If the student has had malaria, he/she should bring malaria medication to take for 6 weeks.

Malaria medication and dosage:

Does the student have allergies (medications, food, environmental, seasonal, insect bites, etc.)?
Please specify and indicate type of reaction.

Has the student had any past surgeries or hospital stays? If yes, please explain.

Does the student take any medications (over-the-counter or prescribed by a physician)? If so, please list:

Has the student received past counseling or psychiatric services? If yes, please explain.

Name of Student _____ Date of Birth _____

Medical Examination *(These 2 pages must be filled out by a physician in conjunction with a physical examination)*

Height _____

Weight _____

Blood Pressure _____

Pulse _____

	Normal	Abnormal	Remarks
Head, Ears, Nose, Throat			
Eyes (with ophthalmoscope)			
Hearing			
Neck-Thyroid			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Menstrual			

Sports Participation

May this student participate without restriction in sports activities? _____ Yes _____ No

Tuberculosis Screening *(International Students Only)*

Skin Test Date: _____ Positive/Negative: _____

If test is positive, chest x-ray is required. Attach report, results, and treatment.

Name of Student _____ Date of Birth _____

Immunization Record (Asterisks denote minimum mandatory vaccine to comply with NYS regulations)

Vaccine	Date each dose was given				
	1st Month/Day/Year	2nd Month/Day/Year	3rd Month/Day/Year	4th Month/Day/Year	5th Month/Day/Year
DTP (Diphtheria, Pertussis, Tetanus) 3 doses required	*	*	*		
TD Booster (Tetanus) (must be within 10 years)					
Polio 4 doses required; 3 doses required if last dose given after age 4	*	*	*	*	
MMR (Measles, Mumps, Rubella) 2 doses required, or physician's documentation of disease	*	*	If no immunization, give date student had measles, mumps, and/or rubella:		
Hepatitis B 3 doses required	*	*	*		
Varicella Vaccine, positive titer, or physician's documentation of disease 2 doses required	*	*	If no immunization, give date student had chickenpox:		
Meningococcal 2 doses required if age 16 and under 1 dose required if first dose given after age 17	*	*			

Boarding students: Houghton Academy complies with New York State regulations governing immunization requirements. Any required immunizations not obtained prior to your arrival will be administered after you arrive, and any fees for obtaining them will be billed to the student's account.

Physician Information

Physician's Signature or Stamp Required _____ Date _____

Physician's Name (Please print) _____

Physician's Address _____

City _____ State/Province _____ Country _____ Zip/Postal Code _____

Physician's Phone (include ALL country, city, and area codes) _____ Physician's Fax Number (include ALL country, city, and area codes) _____