Using the free Acrobat Reader, you may open this form and type directly onto it (you cannot save what you type, however, unless you have the full Acrobat program.) Alternately, you may print these pages and complete them by hand.

Houghton Academy

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E-Mail: Admissions@HoughtonAcademy.org
Website: www.houghtonacademy.org

MEDICAL INFORMATION FORM Please print or type.

☐ Male ☐ Female

First Name Middle Name Family Name Date of Birth (Mo/Day/Year)

Home Address Home Address (continued)

City State/Province Country Zip/Postal Code

Social Security Number (if any)

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 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 old or 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 Fax 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 Contact Person's Address

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

Fax Number (include ALL country, city, and area codes) E-Mail Address (must be English-speaking/reading contact person)

 Name of Student ______________________ Date of Birth ______________

Health Insurance Information for U.S. CITIZENS ONLY

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

____
Name of Insurance Company

____
Address if Insurance Company

____
Insurance Company Phone Number (include area code)

Coverage Details

Does your insurance carry a deductible? ☐ Yes ☐ No If "yes" how much? ______________________
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 NON-U.S. CITIZENS ONLY

All international students 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 nurse's office.

THIS FORM MUST BE COMPLETED AND RETURNED PRIOR TO ENROLLMENT. THIS FORM IS **NOT REQUIRED** FOR ADMISSION. YOUR APPLICATION FOR ADMISSION WILL BE EVALUATED WITH OR WITHOUT THIS FORM.

Name of Student ____ Date of Birth _______________________

This page may be completed by a parent or a physician, but not the student.

Allergies and Sensitivities

Is there a history of skin reaction or other reaction or sickness following injections or oral administration of any of the following?
If yes, please note the **DATE** and **TREATMENT**

NO	YES(DATE)	ITEM	TREATMENT
		Penicillin or other antibiotics	
		Morphine, Codeine, Demerol, other narcotics	
		Aspirin, empirin or other pain remedies	
		Tetanus, antitoxin or other serums	
		Any foods, such as egg, milk, chocolate, or nuts	
		Pets/Animals (Please explain)	
		Novocaine or other anesthetics	
		Sulfa drugs	
		Adhesive tape or latex (circle which)	
		Iodine or merthiolate	
		Any other drug or medication	
		Any other allergies? If yes, please explain below.	

Additional Explanation of Allergies/Treatments:

Medical History

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

NO	YES(DATE)			NO	YES(DATE)	
		Measles				Spitting up blood
		Mumps				Chronic or frequent cough
		Chickenpox				Asthma
		Epilepsy				Spitting up blood
		Diabetes				Fainting
		Concussion or Head Injuries				Headaches
		Rheumatic Fever or Heart Disease				Nosebleeds
		Eating Disorder (anorexia/bulimia)				Chronic sinus trouble
		Hepatitis				Impaired hearing
		Malaria* *				Dizziness
		Strokes				Cancer
		Tuberculosis				Severe Acne
		Fractures or Broken bones Which bones? Dates:				Do you wear glasses/contacts? *(Please bring an extra pair of glasses or contacts with you.)*

If the student has had malaria, he/she should bring malaria medicine to take for six (6) weeks.

Please note the name of the malaria medication:

Please note the dosage:

Name of Student ____ Date of Birth ____________________

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

Normal	Check Each Item	Abnormal
	Head, Face, Neck, Scalp	
	Nose	
	Sinuses	
	Mouth and Throat	
	Ears, General (Int. and Ext.)	
	Drums (perforated)	
	Eyes	
	Ophthalmoscopic	
	Pupils	
	Ocular Motility	
	Lungs and Chest	
	Heart	
	Vascular System	
	Abdomen and Viscera	

Normal	Check Each Item	Abnormal
	Anus and Rectum	
	Endocrine System	
	G – U System	
	Upper Extremities	
	Feet	
	Lower Extremities	
	Spine, Other Musculoskeletal	
	Body Marks, Scars, Tattoos	
	Skin, Lymphatics	
	Neurologic	
	Psychiatric	
	Menstruation (Female Only)	

MEASUREMENTS AND OTHER FINDINGS

Height: ________________ Weight: ________________ Build: slender medium heavy

BLOOD PRESSURE

Sitting: ____________________

PULSE

Sitting: ____________________

SPORTS PARTICIPATION

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

GENERAL HEALTH QUESTIONS

No Yes Any past surgeries or hospital stay? If yes, please explain.

No Yes Any past counseling or psychiatric services? If yes, please explain.

MEDICATIONS

No Yes Do you plan to bring any medications or herbs with you to Houghton Academy? *If yes, you must provide, in **English**, a listing with the **name** of the drug or herb, the **indication**, the **strength,** and **reason** for its use. All medications brought to the Nursing Office upon arrival.*

Physician's Signature or Stamp Required Date

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 are required)		*	*	*		
TD Booster (Tetanus) (must be within 10 years)						
POLIO Vaccine **IPV -4 doses are required**		IPV 1*	IPV 2*	IPV 3*	IPV 4*	IPV 5
-OR- OPV -3 doses are required		OPV 1*	OPV 2*	OPV 3*		
MMR (Measles, Mumps, Rubella, combined) 2 Doses are required		*	*			
OR	**Measles (Rubeola: 10 day red measles) (2 doses of individual vaccine required)	*	*	If no immunization, give date student had Measles:		
	**Rubella (German Measles – 3 days) (1 dose of individual vaccine required)	*	If no immunization, give date student had Rubella:			
	**Mumps (1 dose of individual vaccine required)	*	If no immunization, give date student had Mumps:			
Hepatitis B (3 doses are required)		*	*	*		
Varicella (Vaccine, positive titer, or physician's documentation of disease for student entering grade 7)			If no immunization, give date student had Chickenpox:			
Other Vaccines Received (Please list vaccine(s) with dates)						

**If the student has had measles, mumps, or rubella, and has not received a vaccine for it, a positive titer (blood test) to document immunity must be submitted. A paper from the doctor must be included.

Tuberculosis Clearance (International Students Only)

Skin Test: Date: _____________________________ Positive or Negative: ____________________________

If skin Test is POSITIVE, an X-Ray is required:

Chest X-Ray: Date ___________________________ Positive or Negative: ____________________________

If chest x-ray is positive, what treatment was given? ____

Physician Information

____
Physician's Signature or Stamp Required Date

____
Physician's Name (Please print)

____
Physician's Address

____
Physician's Address (continued) 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)

ATTENTION, 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.