



## MEDICAL INFORMATION

### STUDENT

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_

### FAMILY PHYSICIAN

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### INSURANCE

Insurance Carrier \_\_\_\_\_

Medicaid Carrier \_\_\_\_\_

Name of Insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group ID \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

In an emergency, if I cannot be reached at the above number(s), I hereby give my consent for (1) the administration of any treatment deemed necessary by a licensed physician or dentist; and (2) the transfer to any hospital reasonably accessible.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Last Name

**CURRENT HEALTH PROBLEMS**

Does the student have any current health problems?  Yes  No

If yes, identify and describe: \_\_\_\_\_

\_\_\_\_\_

Does the student use an inhaler or need to carry an Epinephrine pen?  Yes  No

If yes, identify and describe the condition: \_\_\_\_\_

\_\_\_\_\_

Does the student have any dietary restrictions?  Yes  No

If yes, please identify and describe: \_\_\_\_\_

\_\_\_\_\_

**DENTAL AND VISION**

Date of the Last Dental Examination: \_\_\_\_\_

Is the student currently under treatment with an orthodontist?  Yes  No

Indicate if she is fitted with:  Braces  Retainer

Do you want the student to continue with orthodontic care while enrolled?  Yes  No

Date of Last Eye Examination: \_\_\_\_\_

Corrected Vision Required:  None  Reading  Classroom  All the time

Type:  Glasses  Contact Lenses

**ATTENTION OR EMOTIONAL DIFFICULTIES**

If at any time the student has been diagnosed as having attention or emotional problems:

What was the diagnosis and when was it made? \_\_\_\_\_

Who made that diagnosis? \_\_\_\_\_ Phone \_\_\_\_\_

**VACCINATIONS**

Is the student up to date on all vaccinations?  Yes  No

Dates of most recent vaccinations:

Diphtheria / Tetanus \_\_\_\_\_

Polio \_\_\_\_\_

MMR \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Hepatitis B \_\_\_\_\_

\_\_\_\_\_  
Student's Last Name

**MEDICAL HISTORY**

Has the student ever been hospitalized or undergone surgery?  Yes  No

If yes, please describe circumstances and give dates: \_\_\_\_\_

Has the student ever had a broken bone?  Yes  No

If yes, please describe circumstances and give dates: \_\_\_\_\_

Indicate any of the following diseases or illnesses the student now has or experienced in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive           | <input type="checkbox"/> Anaphylactic shock          | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Anorexia/Bulimia            | <input type="checkbox"/> Appendicitis                | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Back injury                 | <input type="checkbox"/> Bladder or Kidney infection | <input type="checkbox"/> Bone condition          |
| <input type="checkbox"/> Bowel problems              | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Chest pains             |
| <input type="checkbox"/> Chicken pox                 | <input type="checkbox"/> Convulsions or seizures     | <input type="checkbox"/> Chronic cough           |
| <input type="checkbox"/> Cysts/tumors                | <input type="checkbox"/> Dermatitis (eczema)         | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Difficulty walking/lifting  | <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Fainting/dizziness      |
| <input type="checkbox"/> Frequent colds/sore throats | <input type="checkbox"/> Constipation/diarrhea       | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> German measles              | <input type="checkbox"/> Hay fever                   | <input type="checkbox"/> Heart trouble/disease   |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> High blood pressure     |
| <input type="checkbox"/> Hives/skin allergies        | <input type="checkbox"/> Hypoglycemia                | <input type="checkbox"/> Headaches/migraines     |
| <input type="checkbox"/> Knee or ankle injury        | <input type="checkbox"/> Moles or lumps              | <input type="checkbox"/> Meningitis              |
| <input type="checkbox"/> Mononucleosis               | <input type="checkbox"/> Mumps                       | <input type="checkbox"/> Muscle weakness         |
| <input type="checkbox"/> Obesity                     | <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Polio                   |
| <input type="checkbox"/> Red measles                 | <input type="checkbox"/> Rheumatic fever             | <input type="checkbox"/> Scarlet fever           |
| <input type="checkbox"/> Scoliosis                   | <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Thyroid disease         |
| <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Urination problems          | <input type="checkbox"/> Venereal disease        |
| <input type="checkbox"/> Whooping Cough              | <input type="checkbox"/> Other: _____                |  |

Please give any important details about the items you selected above: \_\_\_\_\_

\_\_\_\_\_

Have any of the student's close relatives had any of the above diseases/illnesses?  Yes  No

If yes, list and describe: \_\_\_\_\_

\_\_\_\_\_

**OTHER MEDICAL CONCERNS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**PO BOX 1377, NEEDVILLE, TX 77461  
PHONE: 979-793-3011 FAX: 979-793-3034**

To \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Patient/Student \_\_\_\_\_

I hereby authorize you to provide the following information by mail or fax to Fulshear Ranch Academy:

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**CURRENT MEDICAL CONDITION**

Current Diagnosis \_\_\_\_\_

Allergies \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

**CURRENT MEDICATIONS PRESCRIBED**

Medication	Dosage Time	Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**OTHER MEDICATIONS IN THE PAST YEAR**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SUMMARY OF INTENDED FUTURE TREATMENT, DURATION, RECOMMENDATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Prescribing Doctor Signature

\_\_\_\_\_  
Date