

## STUDENT HEALTH INFORMATION

Student Name \_\_\_\_\_ Circle one: Male Female DOB (mo/da/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Emergency Phone (\_\_\_\_) \_\_\_\_\_

Student's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mother's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## MEDICAL HISTORY

Primary Care Physician \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Check any of the following conditions that apply to you. List medications you take for that condition.

\_\_\_ ADHD/ADD \_\_\_\_\_

Allergies \_\_\_\_\_

\_\_\_ Diabetes \_\_\_\_\_

\_\_\_ Asthma \_\_\_\_\_

List any other medications you are currently taking:

\_\_\_ Seizure disorder \_\_\_\_\_

List any serious illnesses or surgeries with date: \_\_\_\_\_

\*\*Please attach any other medical information and/or family history that will assist Milo or the emergency care givers.

### Insurance Information

Primary Provider \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Insured's ID # \_\_\_\_\_

**Attach a copy of insured's medical insurance card.**

## CONTINUING CONSENT TO TREATMENT & AUTHORIZATION TO RELEASE INFORMATION

We, the undersigned parents or guardians of \_\_\_\_\_ (student name), do hereby consent to x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or specific instruction of any doctor the school or organization may call, whether such diagnosis is rendered at the office of said physician or at a licensed hospital. It is understood that the parent or guardian will be responsible for any medical expenses incurred by the student.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Milo Adventist Academy or the physician to exercise their best judgement as to the requirements of such diagnosis or treatment. This consent shall remain in continuous effect throughout the next eighteen months unless revoked in writing and delivered to Milo Adventist Academy.

We hereby authorize any hospital, physician or other person who has attended or examined the person named above to furnish to our insurance companies or their representatives, any and all information with respect of any illness, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photo copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Date

## CONSENT FOR MEDICATION ADMINISTRATION

Students frequently request over-the-counter medications for ailments such as headaches, coughs and colds, allergies, stomach upset, and relief of menstrual discomfort. Under Oregon state law, school personnel may administer such medications only with written parental consent and in compliance with the instructions of a physician. If you wish to have medications available to your student while at MAA, the following conditions must be met:

- Specify which medications you authorize school personnel to administer to your student and sign the consent form below.
- It is the responsibility of parents to see that refills are provided as needed.
- The student agrees to keep medications for personal use only. Student signature below is an agreement not to share meds with other students.

## PARENTAL CONSENT

I hereby authorize any person or persons designated by the Principal of Milo Adventist Academy to assist my child named above to take the following medications at school:

Over-the-counter medications, as directed on package:    yes    no

Prescription medications as ordered by a physician:    yes    no

Medications which I **do not** want my student to receive:

\_\_\_\_\_  
I understand that students are responsible for administration of their own medications and I will not hold Milo Adventist Academy liable for misuse of medication by students.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

## STUDENT AGREEMENT

I understand that my medications are for my personal use only and will not share medications with others.

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

\_\_\_\_\_  
Date

**ATTACHMENTS: All students: current medical insurance card.  
New students: immunization record**