FAIRWOLD ACADEMY at PHMC
Formerly Wordsworth Academy

Student Information Medical Form 2018-2019 SY

Student's Name:	D.O.B:
Home Address:	Phone #
Parent/Guardian:	

Emergency Contact Name(s):	Phone #	Relationship
1.		
2.		
3.		

Medical

Primary Care Physician	Phone:
	Fax:
Psychiatrist (if applicable)	Phone:
	Fax:
Dentist	Phone:
	Fax:
Medical Insurance Co.	Phone:
	Fax:
Primary Cardholder:	Member ID #:

Diagnoses	Date of last Tetanus Shot: / /
1.	4.
2.	5.
3.	6.

Please list prescribed medications. All medications given at school MUST:

- *Be accompanied by a prescription or doctor's orders*
- *Be in a properly labeled bottle from the pharmacy*
- *Be given to the school nurse*

Medications	Dosage	Time given (if applicable)
1.		
2.		
3.		
4.		

Allergies *(food, bee sting, seasonal etc.)*	
1.	4.
2.	5.
3.	6.

Epi-Pen Needed? ☐ Yes ☐ No

Please check if the student has any of the following or has had a history of the following:

- ☐ Tonsillitis
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Chronic Ear Infection
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Repeated Colds
- ☐ Pneumonia
- ☐ Epilepsy/Seizures
- ☐ Fifth Disease
- ☐ German Measles
- ☐ Glandular Disorder
- ☐ Strep Throat
- ☐ Nervous
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ High Fevers
- ☐ Kidney Disorder
- ☐ Mumps
- ☐ Measles
- ☐ Persistent Cough
- ☐ Hernia
- ☐ Onset of Menstruation
- ☐ Other (Specify):___________

If emergency treatment is required, the school authority will use their own judgment in sending your child to the closest hospital. In addition, we, the parent/guardian, agree to assume the responsibility of all expenses incurred by the handling of an emergency situation.

Parent/Guardian Signature	**Date**