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COSMOPOLITAN SCHOOL

MEDICAL FORM

(For Official Use) Student # Grade Academic Year

PARENTAL APPROVAL TO ADMINISTER HEALTH CARE AT SCHOOL

Name of applicant (BLOCK LETTERS)

_____ _____ _____ _____

First | Middle (If applicable) | Father's name (If applicable) | Family or last name

Date of birth _____ Gender: ☐ Female ☐ Male

MM/DD/YY

Home Number _____ Mother's Phone # _____

Father's Phone # _____

Persons to inform in case of emergency if parents or guardians are unreachable:

1. Name: Relation: Home Phone: Cell Phone

2. Name: Relation: Home Phone: Cell Phone:

Pediatrician's Name: Phone #(s):

The school will not administer any medication nor provide any health care or screening to children without written permission from their parents. We urge you to complete this form and return it with the application.

☐ Yes, the school nurse has my permission to give my child **over-the-counter medicines** (e.g. analgesia, antipyretic, cough medicines, and throat lozenges) or antiseptic agents for wounds (in case needed).

☐ Yes, if any child or legal ward of mine enrolled at CS appears to require **immediate medical treatment and/or surgery** where neither my spouse nor I are available to authorize a doctor to proceed therewith, I authorize the School's Headmaster, or, in his/her absence or inability to act, the Acting Headmaster, to take whatever action is deemed necessary to ensure the provision of any necessary permit or authorization.

☐ Yes, I hereby authorize the **school nurse to release information** contained in this document to other health professionals or school administrators whenever it is medically needed for the care of my child.

☐ Yes, the school nurse has my **permission to perform** a physical screening (height, weight measurements, dental, hearing & Vision check) for my child on an annual basis.

BLOOD TYPE OF THE CHILD:

The school urges you to complete this form as accurately as possible. Information requested herein in addition to the school screening examination are done in order to ensure that our students are at their maximal learning capacity and able to participate in the various school activities. They are not a replacement for your child's physician's medical assessment.

My signature acknowledges that I have read and understood all the above:

_____ _____

Parent's Signature Date

STUDENT'S MEDICAL HISTORY - to be completed by parent / guardian

1. History:
Check any of the following the student has or may have had:
Please note: none of the information on this form will be used in admissions decisions.

- ☐ Abnormal bleeding/bruising
- ☐ ADHD/ADD
- ☐ Allergies (Medications, bee sting, pollen, food, etc.)
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Broken bones/stress fracture
- ☐ Cancer
- ☐ Chest pain during exercise
- ☐ congenital heart disease
- ☐ Concussion or head injury
- ☐ Constipation
- ☐ Diabetes
- ☐ Dislocation (shoulder, etc.)
- ☐ Ear problems
- ☐ Eczema
- ☐ Eye or vision problems
- ☐ Fainting with or without exercise
- ☐ Gastrophageal reflux disease (GERD)
- ☐ Hearing impairment
- ☐ Heart murmur/palpitations
- ☐ Heat stroke or heat exhaustion
- ☐ Hepatitis/jaundice
- ☐ High blood pressure
- ☐ Hospitalization
- ☐ Learning difficulty
- ☐ Loss of consciousness
- ☐ Loss of eye sight
- ☐ Positive PPD (Tuberculosis skin test)
- ☐ Rheumatic fever
- ☐ Scoliosis (curvature of spine)
- ☐ Seizures
- ☐ Sickle-cell disease
- ☐ Single organs (kidney, eye, etc.)
- ☐ Speech problems
- ☐ Sudden death in the family before age 35
- ☐ Sudden death in the family before age 50
- ☐ Tuberculosis
- ☐ Undescended testicle
- ☐ Wheezing or cough during or after exercise

If any of the above is checked, please explain or attach a medical report:

_____

Date of diagnosis: _____ Treatment: _____

2. Surgery: Type Body Site: Date

3. Immunizations: Attach copy of recent vaccination records.

4. Does the student have any other medical condition about which CS should be informed? ☐ Yes ☐ No if yes, please explain

_____

_____

5. Is your child taking any chronic medication(s): ☐ Yes ☐ No if yes, please list:

Medication name:	Dose:	Frequency/Times of day:
a) _____	_____	_____
b) _____	_____	_____
c) _____	_____	_____

6. Please state any medication / or food your child is allergic to:

_____

_____

7. Does your child have a prosthesis (medical device)? ☐ Yes ☐ No if yes, please specify:

_____

_____

Parent's/Guardian's signature verifying above information

_____ _____ _____

Parent's Name Parent's Signature Date