



Baylor School Student Health Services

Summer Programs Health Form

To the Examiner: Please review the student's medical history and complete the following Physical Examination Form. Comment on all positive findings and on any significant medical condition(s).

Last Name: _____ First Name: _____ MI: _____
Date of Birth: ____/____/____ M F Corrective Lenses: Yes No if yes: Contact Lenses Glasses

List Current Medications

Name	Dose	Frequency

***Note: Please complete the Physician Orders for Prescription Medication form (see other side) if student is to be on medication to be dispensed by the Baylor School Student Health Services.**

Athletic Participation: No Athletic Participation Limited Athletic Participation Unlimited Athletic Participation

Comments: _____

Signature of Health Care Provider: _____

Provider Name (please print): _____

Provider Address: _____

Student Health History (to be completed by parent or guardian)

Has the student any of the following?

Allergies	Yes	No	Diagnosis	Yes	No
Bees/Hornets			ADD		
Eggs			ADHD		
Foods			Asthma		
Latex			Concussion		
Peanuts			Diabetes		
Nuts			Heart Trouble		
Shellfish			Seizures		
Drugs			Other		
Carries Epi Pen			If other please explain:		
Seasonal Allergies					

Is there a family history of heart disease? Yes No

Yes No

Has student ever had to stop playing in an activity because of chest pain or shortness of breath? Yes No

Does student need a special diet? Yes No

If so, type: _____

Hospitalizations, operations or serious injuries (give dates): _____

Chronic or recurring illness? Yes No

Other diseases or details of above? _____

If yes to any of the above, please comment: _____

Parent/Guardian Signature: _____ Date: _____



Student Name: _____

Baylor School Summer Programs

CONTACT INFORMATION AND RELEASE FOR MEDICAL TREATMENT

IN CASE OF EMERGENCY

When Parent(s)/Guardian(s) cannot be reached, please call: _____

Relationship to student: _____ Home Phone: _____

Home Address: _____

City/State/Zip: _____

Work Phone: _____ Cell Phone: _____

RELEASE FOR EMERGENCY MEDICAL TREATMENT

As custodial parent or guardian of (child's full name) _____ I do here by authorize the trustees, teachers, and officers of Baylor School to take my child to any hospital emergency room for treatment, without first obtaining my consent in the event my child is sick, hurt, or in need of medical attention and it is impossible or impractical for a representative of Baylor School to get in touch with me prior to obtaining medical attention for my child. I do further release and absolve Baylor School, its trustees, teachers, and officers from any liability as a result of obtaining such medical treatment for my child.

Further, I authorize the doctor or doctors, nurses, hospital or emergency room of any hospital to render the treatment necessary for the illness, sickness, or injury of my child who is brought to such institution for treatment.

Custodial Parent/Guardian (printed name): _____ Signature: _____

Date: _____

MEDICAL RELEASE AND AUTHORIZATION

I hereby give consent for the personnel of the Baylor School Student Health Services or other health care providers it utilizes to carry out accepted procedures for diagnosis, immunizations, medical treatment, minor surgical treatment, emergency surgery including anesthesia, dental/orthodontic surgery procedures, or counseling of my child. I authorize the health care institutions and physician caring for my child to release copies of medical and psychological records to Baylor School.

Parent/Guardian Signature: _____ Date: _____

OVER-THE-COUNTER MEDICATION RELEASE AND AUTHORIZATION

Over-the-counter medications include any medication readily bought at area pharmacies and approved by the Baylor School physician and kept in the Baylor School Student Health Services. (Advil, Tylenol, etc.) I give permission for my child to receive such over-the-counter medication as needed unless contraindicated by their current health history and medication allergies. Please list any medications below that SHOULD NOT be administered to your child.

Parent/Guardian Signature: _____ Date: _____

ALL STUDENTS (Please enclose a front and back copy of insurance, dental and prescription cards.)

Medical Insurance Carrier: _____ Policy Holder: _____

SS# of Policy Holder: _____ Date of Birth: _____ Employer: _____

Policy No.: _____ Group ID No.: _____ Pre-Authorization Needed? YES NO

Insurance Company Address: _____ Insurance Company Phone: _____

Prescription Plan and No. (if applicable): _____ Dental Plan and No.: _____