PROJECT D.E.E.P. (DORCHESTER EDUCATIONAL ENRICHMENT PROGRAM)
HEALTH INFORMATION FORM

■ STUDENT AND PARENT INFORMATION: PLEASE INCLUDE INFORMATION FOR PARENT(S) or GUARDIAN(S) LIVING AT HOME ■

STUDENT NAME: _____ BIRTH DATE: _____ AGE: _____ ☐ MALE ☐ FEMALE

PARENT or GUARDIAN: _____ PHONE: _____ PHONE: _____

HOME ADDRESS: _____

INSURANCE CARRIER: _____ POLICY or GROUP № : _____ HOLDER: _____

■ ADDITIONAL EMERGENCY CONTACT PERSONS: INCLUDE NAME, RELATIONSHIP, and PHONE NUMBER ■

EMERGENCY CONTACT #1: _____ RELATIONSHIP: _____ PHONE: _____

EMERGENCY CONTACT #2: _____ RELATIONSHIP: _____ PHONE: _____

PHYSICIAN CONTACT: _____ FACILITY: _____ PHONE: _____

CURRENT MEDICATIONS

NAME	DOSAGE and DOSING SCHEDULE
_____	_____
_____	_____
_____	_____
_____	_____

☐ I AUTHORIZE THE ADMINISTRATION OF ACETAMINOPHEN OR TYLENOL TO MY CHILD, IF REQUESTED, AT THE PHYSICIAN'S RECOMMENDED DOSAGE.

ALLERGIES

INDICATE ALLERGIES AND DESCRIBE REACTION BELOW

☐ MEDICATION

☐ ENVIRONMENTAL or SEASONAL

☐ INSECT or BEE

☐ FOOD

☐ NO KNOWN DRUG ALLERGIES

STUDENT HEALTH HISTORY

IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK THE APPROPRIATE BOX. EXPLAIN IN THE SPACE BELOW.

SKIN
☐ Eczema
☐ Insect Bites or Stings
☐ Poison Ivy, Oak, Sumac, etc.
☐ Rash
☐ Other SKIN

EYES
☐ Blindness
☐ Color Blindness
☐ Eye Injury or Disease
☐ Wears Contacts or Glasses
☐ Other EYES

EARS / NOSE / THROAT
☐ Frequent Ear Infections
☐ Frequent Sore Throats
☐ Hearing Loss or Deafness
☐ Repeated Nosebleeds
☐ Sinus Infections
☐ Other EARS / NOSE / THROAT

DENTAL
☐ Frequent Oral Pain
☐ Other DENTAL

RESPIRATORY
☐ Asthma
☐ Bronchitis
☐ Chronic Cough
☐ Pneumonia

CARDIAC
☐ Chest Pain
☐ Heart Murmur
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Rate
☐ Palpitations
☐ Other CARDIAC

GASTROINTESTINAL
☐ Gallbladder Problems
☐ Hepatitis
☐ Hernia
☐ Irritable Bowel Problems
☐ Requires Special Diet
☐ Stomach Problems
☐ Ulcer
☐ Other GASTROINTESTINAL

MUSCULOSKELETAL
☐ Arthritis
☐ Back, Spine, Disc, Joint Problems
☐ Fractures or Dislocations
☐ Frequent Back Pain
☐ Joint Disease
☐ Scoliosis
☐ Other MUSCULOSKELETAL

NEUROLOGICAL
☐ Concussion
☐ Dizziness or Fainting
☐ Epilepsy or Seizures
☐ Frequent Headaches
☐ Migraines
☐ Neuromuscular Disorder
☐ Severe Head Injury
☐ Other NEUROLOGICAL

MENTAL HEALTH
☐ Anxiety Spectrum Disorders
☐ Attention Deficit (ADD or ADHD)
☐ Autism Spectrum Disorders
☐ Clinical Depression
☐ Eating Disorders
☐ Other MENTAL HEALTH

ENDOCRINE
☐ Diabetes
☐ Other ENDOCRINE

HEMATOLOGIC
☐ Anemia
☐ Bleeding Disorder
☐ Clotting Disorder
☐ Frequent Bruising
☐ Iron Deficiency
☐ Sickle Cell Trait or Disease
☐ Other HEMATOLOGIC

INFECTIOUS DISEASE
☐ Chicken Pox
☐ German Measles
☐ Malaria
☐ Measles
☐ Mumps
☐ Mononucleosis (“Mono”)
☐ Meningitis
☐ Whooping Cough
☐ Other INFECTIOUS DISEASE

PLEASE DESCRIBE ANY BOXES INDICATED ABOVE OR OTHER INFO. INCLUDE WHETHER ANY PROBLEM IS CURRENT, AND DATES IF APPLICABLE.

_____

_____

_____

■ THE SECTION BELOW <u>MUST</u> BE COMPLETED FOR ATTENDANCE ■

MY CHILD HAS UNDERGONE A PHYSICAL EXAM WITHIN THE LAST YEAR, AND THE HEALTH HISTORY AS DETAILED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND THE PERSON HEREIN HAS THE PERMISSION TO ENGAGE IN ALL PRESCRIBED ACTIVITIES EXCEPT AS NOTED.

DATE: _____ SIGNATURE: _____