

# 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 No: \_\_\_\_\_ 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.

- |  |  |   |   |
|--|--|---|---|
| <b>SKIN</b><br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Insect Bites or Stings<br><input type="checkbox"/> Poison Ivy, Oak, Sumac, etc.<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Other SKIN   | <b>RESPIRATORY</b><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Chronic Cough<br><input type="checkbox"/> Pneumonia   | <b>MUSCULOSKELETAL</b><br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Back, Spine, Disc, Joint Problems<br><input type="checkbox"/> Fractures or Dislocations<br><input type="checkbox"/> Frequent Back Pain<br><input type="checkbox"/> Joint Disease<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Other MUSCULOSKELETAL                                   | <input type="checkbox"/> Other MENTAL HEALTH<br><b>ENDOCRINE</b><br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Other ENDOCRINE<br><b>HEMATOLOGIC</b><br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Bleeding Disorder<br><input type="checkbox"/> Clotting Disorder<br><input type="checkbox"/> Frequent Bruising<br><input type="checkbox"/> Iron Deficiency<br><input type="checkbox"/> Sickle Cell Trait or Disease<br><input type="checkbox"/> Other HEMATOLOGIC |
| <b>EYES</b><br><input type="checkbox"/> Blindness<br><input type="checkbox"/> Color Blindness<br><input type="checkbox"/> Eye Injury or Disease<br><input type="checkbox"/> Wears Contacts or Glasses<br><input type="checkbox"/> Other EYES   | <b>CARDIAC</b><br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Irregular Heart Rate<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Other CARDIAC  | <b>NEUROLOGICAL</b><br><input type="checkbox"/> Concussion<br><input type="checkbox"/> Dizziness or Fainting<br><input type="checkbox"/> Epilepsy or Seizures<br><input type="checkbox"/> Frequent Headaches<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Neuromuscular Disorder<br><input type="checkbox"/> Severe Head Injury<br><input type="checkbox"/> Other NEUROLOGICAL | <b>INFECTIOUS DISEASE</b><br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> German Measles<br><input type="checkbox"/> Malaria<br><input type="checkbox"/> Measles<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Mononucleosis ("Mono")<br><input type="checkbox"/> Meningitis<br><input type="checkbox"/> Whooping Cough<br><input type="checkbox"/> Other INFECTIOUS DISEASE  |
| <b>EARS / NOSE / THROAT</b><br><input type="checkbox"/> Frequent Ear Infections<br><input type="checkbox"/> Frequent Sore Throats<br><input type="checkbox"/> Hearing Loss or Deafness<br><input type="checkbox"/> Repeated Nosebleeds<br><input type="checkbox"/> Sinus Infections<br><input type="checkbox"/> Other EARS / NOSE / THROAT | <b>GASTROINTESTINAL</b><br><input type="checkbox"/> Gallbladder Problems<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Irritable Bowel Problems<br><input type="checkbox"/> Requires Special Diet<br><input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Ulcer<br><input type="checkbox"/> Other GASTROINTESTINAL | <b>MENTAL HEALTH</b><br><input type="checkbox"/> Anxiety Spectrum Disorders<br><input type="checkbox"/> Attention Deficit (ADD or ADHD)<br><input type="checkbox"/> Autism Spectrum Disorders<br><input type="checkbox"/> Clinical Depression<br><input type="checkbox"/> Eating Disorders  |   |

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

\_\_\_\_\_  
 \_\_\_\_\_

**■ THE SECTION BELOW MUST 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: \_\_\_\_\_