



P O R T S M O U T H A B B E Y S C H O O L

REQUIRED FOR ENROLLMENT

HEALTH FORM

This information is CONFIDENTIAL and is not part of the permanent transcript.
The legal guardian must complete the form; and the physical exam must be completed by the physician WITHIN 6 months prior to the beginning of school.

Student's Name _____

Birth date _____ Social Security # _____

Home Address _____

City _____ State _____ Zip _____

Student resides with: Both Parents _____ Mother _____ Father _____ Other _____

Student's Cell Phone _____

Father's Full Name _____

Father's Address _____

Residence Phone _____ Business Phone _____

Cell Phone _____ FAX _____

Email _____

Mother's Full Name _____

Mother's Address _____

Residence Phone _____ Business Phone _____

Cell Phone _____ FAX _____

Email _____

Guardian's Full Name _____

Address _____

Residence Phone _____ Business Phone _____

Cell Phone _____ FAX _____

Email _____

Alternate responsible person (not parent) to be reached in case of emergency if above not available.

Name _____

Address _____

Phone #s _____

Student's Name _____

Student History: to be filled out by the student and the parent --If you answer yes, please explain fully on a separate sheet of paper if necessary.

	Yes	No	Explanation:
1. Are you on any medication? (if yes attach list)	Yes	No	
2. Do you have any allergies (medication, bee stings, food, latex)?	Yes	No	
3. If so do you require an EpiPen?	Yes	No	
4. Have you ever been hospitalized overnight?	Yes	No	
5. Have you ever had any surgery?	Yes	No	
6. Have you ever passed out during exercise or in the heat?	Yes	No	
7. Have you ever had chest pain?	Yes	No	
8. Do you tire more quickly than your friends during exercise?	Yes	No	
9. Have you ever been told you have a heart murmur?	Yes	No	
10. Have you ever had high blood pressure?	Yes	No	
11. Has your heart ever raced or skipped beats?	Yes	No	
12. Have you fainted?	Yes	No	
13. Has anyone in your family died suddenly at age 40 or younger?	Yes	No	
14. Does anyone in your family have Marfan's syndrome?	Yes	No	
15. Does anyone in your family have Long QT syndrome?	Yes	No	
16. Have you ever had Asthma?	Yes	No	
17. Ever required Prednisone for the treatment of Asthma?	Yes	No	
18. Do you have any skin problems?	Yes	No	
19. Do you have eye trouble?	Yes	No	
20. Do you have ear, nose, or throat trouble?	Yes	No	
21. Have you ever been diagnosed with Tuberculosis?	Yes	No	
22. Do you get recurrent headaches?	Yes	No	
23. Have you ever had any head injury or concussion?	Yes	No	
24. If so how many times?			
25. Do you or have you ever had seizures?	Yes	No	
26. Have you ever had paralysis?	Yes	No	
27. Have you ever been evaluated for a learning disorder?	Yes	No	
28. Do you suffer from excessive worry, anxiety, or nervousness?	Yes	No	
29. Do you have trouble with insomnia?	Yes	No	
30. Have you ever felt depressed?	Yes	No	
31. Have you had any recent change in weight?	Yes	No	
32. Do you think you are too fat or too thin?	Yes	No	
33. Do you have any joint or back problems?	Yes	No	
34. Have you had any fractures of back or neck?	Yes	No	
35. Do you require any special pads or braces?	Yes	No	
36. Have you had any stomach or intestinal problems?	Yes	No	
37. Have you ever had Hepatitis?	Yes	No	
38. Have you had mononucleosis in the last month?	Yes	No	
39. Do you have sickle cell disease or trait?	Yes	No	
40. Do you have Diabetes?	Yes	No	
41. Do you have problems with frequent urination?	Yes	No	
42. Have you ever had any kidney disease?	Yes	No	
43. Have you ever been diagnosed with any sexually transmitted diseases?	Yes	No	
44. Have you ever been diagnosed with cancer?	Yes	No	
45. For Females: Has menstruation begun?	Yes	No	
46. Do you have menstrual difficulties?	Yes	No	
47. Are you on any hormonal or birth control medication?	Yes	No	
48. Date of most recent Dental exam (must be within 1 year).			_____

Student's Name _____

Family History

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Immunization Record – Day, Month and Year are required.

Immunization	Dates	Immunization	Dates	Immunization	Dates
DPT, Td, Tdap	_____	Polio-OPV/IPV	_____	MMR's	_____
(Specify which)	_____	(Specify which)	_____	2 required	_____
4 required	_____	3 or 4 required	_____	—or—	_____
(one must be	_____	(if three given,	_____	Measles	_____
given over the age of 4)	_____	one must be over the age of	_____	2 required	_____
	_____	four. If IPV and OPV given,	_____	Mumps	_____
Td or Tdap Booster	_____	must have 4)	_____	1 required	_____
Required within 5 years	_____		_____	Rubella	_____
	_____	Tuberculosis skin test	_____	1 required	_____
Varicella	_____	(Mantoux) _____	_____	Hepatitis B	_____
2 if given after	_____	Result: Neg. _____ Pos. _____	_____	Series of 3	_____
age 13 required or	_____	Induration _____	_____		_____
proof of disease	_____	If pos. CXR required.	_____		_____
	_____	Date _____ (Send results)	_____		_____
	_____	Date of BCG _____	_____		_____

Date of Physical Exam _____

Ht _____
Wt _____
BP _____
Pulse _____

Vision L eye 20/ _____
R eye 20/ _____
Both 20/ _____
Hearing Screening _____

Any Abnormalities? Please record below.

Skin _____	<input type="radio"/> Yes	<input type="radio"/> No	Extrem. _____	<input type="radio"/> Yes	<input type="radio"/> No
HEENT _____	<input type="radio"/> Yes	<input type="radio"/> No	Neuro _____	<input type="radio"/> Yes	<input type="radio"/> No
Neck _____	<input type="radio"/> Yes	<input type="radio"/> No	Marfanoid? _____	<input type="radio"/> Yes	<input type="radio"/> No
Nodes _____	<input type="radio"/> Yes	<input type="radio"/> No	Males		
Lungs _____	<input type="radio"/> Yes	<input type="radio"/> No	Testicular exam _____	<input type="radio"/> Yes	<input type="radio"/> No
Heart _____	<input type="radio"/> Yes	<input type="radio"/> No	Females		
Abd _____	<input type="radio"/> Yes	<input type="radio"/> No	GYN optional _____	<input type="radio"/> Yes	<input type="radio"/> No

Is the student capable of participating in a competitive athletic program? Yes No

If no, why? _____

Physician's Signature _____
Signature indicates review of student's history page (separate sheet) and physical

Physician's Name _____

Address _____

Telephone number: _____

Student's Name _____

MEDICAL RELEASE

I hereby give consent for the personnel of the Student Health Services or other health care providers that they elect to carry out accepted procedures for diagnosis, immunizations, medical and minor surgical treatment, or counseling for my (son, daughter, ward).

In rare instances a surgical emergency arises, in which written consent by the parent or guardian is legally required but the proper person cannot be located. In that event, in order to prevent any delay which might jeopardize the life or recovery of a student, we request the following permission from the parents or guardian, with the understanding that every effort will be made to contact them in an emergency.

I hereby grant permission to the personnel of Health Services of Portsmouth Abbey School or other physicians or surgeons considered appropriate by them to give necessary anesthesia and perform emergency medical and/or surgical procedures on my (son, daughter, ward).

NAME _____ DATE _____

Signature _____

INSURANCE INFORMATION

Insurance Company Name: _____

Identification Number: _____ Group Number: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone: _____ Fax: _____

Policyholder's Last Name: _____ First Name & Initial: _____

Social Security number: _____ Date of Birth: _____

Relationship to student: _____

Prescription Coverage: Yes No

Insurance Referral Authorization required? Yes No

Please notify us at 401-683-4462 should there be any changes in your insurance plan or coverage.

My child does NOT have private insurance coverage.

Pharmacy Payment:

I hereby authorize payment to a pharmacy, designated by Portsmouth Abbey School, of any co-payments or unpaid balance after insurance for medications provided to my child.

Charge to: American Express Master Card Visa Discover

Card number: _____ Expiration Date: _____

Signature of Cardholder

Cardholder name (please print)

Date

PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF THE STUDENT'S INSURANCE CARD TO THIS FORM

The School Insurance only covers part of injuries that occur during the school year (illnesses are not covered).

Foreign students may purchase additional insurance that will cover illnesses. Please contact the Business Office for more information.