Milford Academy Admissions Office
P.O. Box 878, New Berlin, NY 13411
Tel: (607) 847-9260 Fax: (607) 847-9250
www.milfordacademy.org

# Health Insurance Information Notification

(Please Print)

This is to inform you that if your son is presently covered by a HMO, the insurance company requires you to ask your primary physician for a referral prior to going to any medical facility. It is therefore necessary for us to have the following information:

## Student Information

Full Name: _____
First Middle Last

Address: _____
Street City State Zip

Grade: _____ Age: _____ Date of Birth: _____/_____/_____

Father/Guardian's Home Phone: (____)_____ Mother/Guardian's Home Phone: (____)_____

Business Phone: (____)_____ Business Phone: (____)_____

## Insurance Company Information

Name of Insurance Company: _____

Address: _____
Street City State Zip

Telephone Number: (____)_____ Fax Number: (____)_____

Subscriber's Name on Policy: _____

Subscriber's Policy/Medical Number: _____

Please provide a copy of both sides of your insurance card for our use.

Thank you for your assistance in this matter.

Milford Academy Admissions Office
P.O. Box 878, New Berlin, NY 13411
Tel: (607) 847-9260 Fax: (607) 847-9250
www.milfordacademy.org

## Permission for Treatment of a Minor

(Please Print)

Instructions: This form must be completed by the parent (s) /guardian of the student is under 18 years of age when they enter Milford Academy.

## Student Information

Full Name: _____
First Middle Last

Address: _____
Street City State Zip

Grade: _____ Age: _____ Date of Birth: _____/_____/_____

Father/Guardian's Home Phone: (____)_____ Mother/Guardian's Home Phone: (____)_____

Business Phone: (____)_____ Business Phone: (____)_____

The following is a list of medications, foods, etc to which the above named student is allergic:

_____

_____

_____

_____

As Parent (s) / Guardian of the above-named student, I hereby grant my consent and authorization for medical care and Treatment by or as approved by physician attending the student.

_____ _____
Parent/Guardian Signature Parent/Guardian Signature

_____ _____ _____ _____
Printed Name Dated Printed Name Dated

Milford Academy Admissions Office
P.O. Box 878, New Berlin, NY 13411
Tel: (607) 847-9260 Fax: (607) 847-9250
www.milfordacademy.org

## Permission for the administration of medicines by School personnel and/or The Milford Health Department

(Please Print)

Instructions: This form must be completed by the parent (s) /guardian for the student if the student is under 18 years of age when they enter Milford Academy. There must also be a signature of the Student's physician.

New York State Law and Regulations require a physician's written order and parent (s) or guardian's authorization for a nurse to administer medicinal preparations exclusive of hallucinogens or narcotics or, in her absence the Headmaster, Dean of Students, or Dormitory Proctor to administer oral Medications.

## Physician's Order for the Following Student

Full Name: _____
First Middle Last

Address: _____
Street City State Zip

Grade: _____ Age: _____ Date of Birth: _____/_____/_____

Father/Guardian's Home Phone: (____)_____ Mother/Guardian's Home Phone: (____)_____

Business Phone: (____)_____ Business Phone: (____)_____

The following is a list of medications, foods, etc to which the above named student is allergic:

_____

_____

_____

Condition for which medication is being administered:_____

_____

Name of medication or drug:_____

Dosage: _____

Time of Administration: _____

Relevant side effects to be observed, if any: _____

Milford Academy Admissions Office
P.O. Box 878, New Berlin, NY 13411
Tel: (607) 847-9260 Fax: (607) 847-9250
www.milfordacademy.org

Other Suggestions: _____

Length of time during which medication shall be administered: From_____ To _____

Physician's Signature: _____

Physician's Name: _____ Dated:_____

Physician's Address: _____

Physician's Telephone: _____

As Parent (s) /guardian of the above-named student, I/We hereby grant my/our consent and authorization for the administration of the above medication by Milford Academy and/or the Milford Health Department.

| | | | |
|---|---|---|---|
| _____ | | _____ | |
| Parent/Guardian Signature | | Parent/Guardian Signature | |
| _____ | _____ | _____ | _____ |
| Printed Name | Dated | Printed Name | Dated |

# State of New York Department of Education
# Health Assessment Record

To Parent or Guardian,

In order to provide the best education experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State Law requires complete primary immunization and a health assessment y a legally qualified practitioner of medicine, an advanced practice nurse or registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in New York. An immunization update and additional health assessments are required in the 10th or 11th grade. Specific grade level will be determined by the local board of education.

## Student Information (Please Print)

_____

Name of Student (Last, First, Middle)

_____ _____ _____

Social Security Number Date Of Birth Sex M/F

_____

Address (Street) City/Town Zip

_____

Name of Parent/Guardian (Last, First, Middle)

_____ _____

Medicaid Number (if Applicable) Health Insurance Company/Number (if Applicable)

## Part I - To be Completed by Parent

**Important: Complete Part I before your child is examined. Take this form with you to the health care provider's office.**

Please answer the following questions with either a YES or NO response in the space provided. In addition please explain all "Yes" answers in the space provided below.

1. Do you have any concerns about your child's general health (eating or sleeping habits, weight, teeth, etc)? _____

2. Does your child have any other specific illness or problems? _____

3. Does your child have any allergies (food, insects, medication, etc)? _____

4. Does your child take any medication (daily or occasionally)? _____

5. Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? _____

6. Has your child had any hospitalization, operation, or major illness (specify problem)? _____

7. Has your child had any significant injury or accident (specify problem)? _____

8. Would you like to discuss anything about your child's health with the school nurse? _____

Please explain any "YES" answers here. For illnesses/injuries/etc; include the year and/or the child's age.

_____

_____

**I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.**

_____ _____
Parent/Guardian Signature Parent/Guardian Signature

_____ _____ _____ _____
Printed Name Dated Printed Name Dated

## Part II - Medical Evaluation

To the Health Care Provider: Please complete and sign.

_____ _____ has had a complete history and physical exam on _____
Student Name Birth Date MM/DD/YY

## Findings for this student are as follows:

Screening/Test Results

Note: Mandated Screening/Tests/Immunizations under New York State Law

*Height _____ * Weight _____ * B/P _____

*Pulse _____ * HTC/HGB _____ Urinalysis _____

*Gross dental (teeth and gums) _____

* Postural: Normal _____ Abnormal _____ Referral _____

Min_____ Slight _____ Mod _____ Marked _____

TB and Other Test Results (Sickle Cell, etc) TB: in high risk group? _____

| TEST | DATE | RESULTS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Vaccine (month/day/year) Note: Minimum requirements prior to school enrollment.
At subsequent exams, note booster shots only.

| Vaccine | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|---|---|---|---|---|---|---|
| DTP | | | | | | |
| DTP/Hib | | | | | | |
| DTaP | | | | | | |
| DT/Td | | | | | | |
| OPV | | | | | | |
| IPV | | | | | | |
| MMR | | | | | | |
| Measles | | | | | | |
| Mumps | | | | | | |
| Rubella | | | | | | |
| HIB | | | | | | |
| Hep B | | | | | | |
| Varicella | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Disease Hx of above _____ _____ _____
Specify Date Confirmed by

## Exemption

Religious _____ Medical: Permanent _____ Temporary _____ Date _____

Re-certify date _____ Re-certify date _____ Re-certify date _____

This student has the following problems, which may adversely affect his educational experience:

Vision _____ Auditory _____ Speech/Language _____

Physical Dysfunction _____ Emotional Social _____ Behavior _____

_____ The pupil has a health condition that may require emergency action at school. E.g. seizures, allergies (specify below)

_____ The pupil is on long term medication. (specify below)

Comments and recommendations (attach additional sheet if necessary):

_____

_____

_____

_____ This student may participate fully in the school program, including physical education activities.

_____ This student may participate in the school program and physical education with the following restriction/adaptation. (Specify reason and restriction)

_____

_____

_____Yes _____ No Based on this comprehensive health history and physical examination, this student has maintained his level of wellness.

_____ I would like to discuss information in this report with the school nurse.

| _____ | _____ | _____ | (____)_____ |
|---|---|---|---|
| Signature of Health Care Provider | Print Name | Date | Phone Number |