SOUTHWESTERN ACADEMY

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MEDICAL RELEASE AND HEALTH STATEMENT

_____
Student's Last/Family Name Student's First Name Date of Birth (Month/Day/Year)

_____ □ Female □ Male _____
Social Security/Green Card/International Student Passport Number Religious Preference (if any)

REPORT OF PHYSICAL EXAMINATION (to be completed by attending physician(s) within the past 12 months)
Date of Examination: _____

Has the applicant ever had any of the following?						Any disease, impairment or abnormality of:		
YES	NO		YES	NO		YES	NO	
		Allergies to drugs			Parasites (intestinal, other)			Abdominal Organs, Digestive System
		Food Allergies			Vertigo, Dizziness			Bones, Joints, Locomotors System
		Smoke Allergies			Rheumatic Fever			Blood, Endocrine System
		Pet Allergies			Eating Disorders			Tonsils, Nose or Throat
		Asthma			Chicken Pox			Varicose Veins
		Appendicitis			Rubella			Brain, Nervous System
		Cough (persistent, recurring)			Scarlet Fever			Ears or Hearing
		Diabetes Mellitus			Hepatitis			Eyes or Vision
		Enuresis			Hernia			Gentio-Urinary System
		Goiter (struma)			Malaria			Heart or Blood Vessels
		Headache (persistent, recurring)			Seizure Disorder			Lungs, Respiratory System
		Learning or Speech Defect			Sleepwalking			Skin (acne, etc.)

If "yes" is checked for any of the above, physician must provide full details. _____
_____
_____

Has the student ever been hospitalized? □Yes □ No If yes, please explain:_____
_____

Has the student ever been advised to have surgery that has not been performed? □Yes □ No If yes, please explain:
_____

Is the student presently taking any medication or injections? □Yes □ No If yes, please explain:_____
_____

Will the student bring any prescription(s) to the school? □Yes □ No If yes, what prescription(s) and how often are they taken?
_____

What is the purpose of each prescription? _____

Has the student ever consulted a neurologist, psychologist, or any other specialist in nervous or emotional disorders? □Yes □ No

If yes, please explain: _____

Is the student still in the care of this specialist? □Yes □ No If yes, please provide the following:

Name(s) of Specialist(s): _____

Specialty: _____ Phone Number(s): _____

Are there any restrictions of any kind in regard to school sports or other activites? □Yes □ No If yes, please explain:
_____

Are there any dietary restrictions for this student? ☐ Yes ☐ No If yes, please explain:_____
_____

Student's Height: _____ Student's Weight: _____

Immunization Record

California and Arizona laws state that students must be adequately immunized before entering school. Please include all dates.
***REQUIRED for entrance.**

VACCINE	**DATE EACH DOSE WAS GIVEN** (must include month, day, and year)					
	1st	2nd	3rd	4th	5th	Booster
***POLIO** (OPV or IPV)	/ /	/ /	/ /	/ /	/ /	
***DPT/DtaP/DT/Td**	/ /	/ /	/ /	/ /	/ /	/ /
***MMR** (Measles, mumps, and rubella) **	/ /	/ /	****Or** two shots of Measles, one of Mumps, and one of Rubella.			
Measles (Rubeola-10day, red measles)	/ /	/ /	If no immunization, give date student had Rubeola: / /			
Mumps	/ /	/ /	If no immunization, give date student had Mumps: / /			
Rubella (German measles – 3 day measles)	/ /	/ /	If no immunization, give date student had Rubella: / /			
***Hepatitis B**	/ /	/ /	/ /			
***Varicella** (Chickenpox)	/ /	/ /	If no immunization, give date student had Chickenpox: / /			
Hepatitis A	/ /	/ /				
BCG	/ /	Please note: the BCG vaccination is not valid in the U.S.				
Other	/ /	/ /	/ /	/ /	/ /	/ /
Other	/ /	/ /	/ /	/ /	/ /	/ /
TB Skin Test □ PPD-Mantoux □ Other	Date given: / /	Date read: / /	mm indur	□ positive □ negative	If the skin test is positive a chest x-ray is needed.	

Your opinion of the student's overall health: ☐ excellent ☐ good ☐ fair ☐ poor

I, the undersigned, have reviewed the medical history of the patient and conducted a thorough physical examination. I certify that all-important information has been noted on this form and that nothing relevant has been omitted.

Physician's Signature: _____ Name (print): _____ Date: _____

Address: _____ Phone Number: _____

CONSENT TO MEDICAL/DENTAL CARE AND AUTHORIZATION TO RELEASE INFORMATION

Parents of students under eighteen years of age must sign the following statement to allow medical or dental care if necessary while the student is enrolled at Southwestern Academy:

I hereby authorize Southwestern Academy to arrange for health care and/or any physician or dentist to give whatever care in their professional opinion is necessary for my minor child while a student at Southwestern Academy. The School and any health care agency and their associated physicians, surgeons, and/or dentists, have my authorization to consult together as necessary. I hereby give my consent to any x-ray examination, anesthetic, medical, psychiatric, or surgical diagnosis or treatment and hospital service, and for the performance of an operation with whatever anesthesia is necessary at the discretion of the surgeon or anesthesiologist, whether such diagnosis or treatment is rendered at the physician's office or at a licensed hospital. It is understood that this consent is given in advance of any specific diagnosis or treatment that may be required and is given to authorize Southwestern Academy, its Headmaster or designee, and physicians to exercise their best judgment as to the requirements of such diagnosis or treatment. It is further understood that this consent authorizes Southwestern Academy to communicate with health care providers regarding diagnosis and treatment, and to have access to the same information regarding diagnosis and treatment accessible to us if we were present. I hereby accept all responsibility for expenses in connection with the above and understand that neither a hospital nor Southwestern Academy is to assume financial responsibility for my minor child. I will honor charges for emergency services as if I had arranged for those services in person. This authorization remains in effect until revoked in writing by me. *I also certify that the information given on both sides of this questionnaire is complete and accurate. I have answered all the questions and disclosed all the details requested. I understand that this form must be signed and dated before my student enters Southwestern, and that inaccurate or misleading information is cause for denial of admission or expulsion of the student if enrolled.*

Parent's Signature: _____ Date: _____

Printed Name: _____ Day Phone: _____ Evening Phone: _____

Mailing Address:
_____

Medical Billing Information (if the student receives medical care, to whom and where the medical bill should be sent?):

Name: _____ Telephone: _____

Address: _____
Address City State/Province Country Zip/Postal Code