Governor Baxter School for the Deaf
Health Form
Academic Year 2013-2014

Before your child can start school, this form must be completed each year and returned by August 30 to Governor Baxter School for the Deaf Health Center, Mackworth Island, Falmouth, Me 04105. Please attach any PERMISSION TO ADMINISTER MEDICATION forms and any additional sheets if necessary. Parents are advised to keep a copy of the completed form for their own records.
DATA BASE: To be completed by parent(s) or guardian. PLEASE PRINT.

Student's name:_____ SEX: M___ F ___ Date of Birth: _____ Grade in Sept. _____

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

Parent/Guardian name: _____ phone: _____ alt. phone: _____

Address: _____

Parent name: _____ Home phone: _____Work phone: _____

Address(if different): _____

List two responsible adults, preferably in the area, to be reached in case of emergency if parent or guardian is unavailable.
Name/relationship: _____ phone: _____ alt. phone: _____
Name/relationship: _____ phone: _____ alt. phone: _____

HEALTH INSURANCE: Mainecare # _____

Name of other insurance company: _____ Phone:_____

Policy # _____I.D. # _____ and/or Group #_____

Student's social security number: _____Policy Holder's Name: _____

STUDENT PROFILE (Use space or back of form to explain)

1.) Any known allergies (include reaction to insect bites) Yes _____ No _____

If yes, list allergy and type of reaction _____

2.) Medications which student currently takes on a regular or "as-needed" basis, both at home and at school. (Please complete the attached *PERMISSION TO ADMINISTER MEDICATION AT SCHOOL* form. Make copies as necessary to fill out one form for EACH medication to be given at school.)_____

3.) Pertinent medical histories (e.g. asthma, diabetes, seizures, etc.) _____

4.) Significant injury/illness since completion of last year's form (e.g. chicken pox, broken bones, mono, etc.)

_____

5.) Date of last physical exam _____ Date of last tetanus shot _____

6.) Student's Primary Care Physician Name: _____Phone: _____

Other Physician Name: _____Specialty:_____Phone:_____

AUTHORIZATION FOR TREATMENT: In the event I cannot be reached, I authorize that medical and/or surgical treatment be secured as may be deemed necessary or advisable for my child. I also authorize release of medical information to insurance companies for the purpose of payment and to health care providers who may treat my child.

Signature (parent or guardian) _____Date _____ (turn over)

FIRST AID and Over the Counter Medication

We have first aid supplies and a few over the counter medications on hand for minor injuries and mild physical symptoms. Please indicate your preferences regarding the following treatments for your child.

	OK to Give	Do Not Give	Call first
Tylenol/ Acetaminophen (age appropriate dose)			
Advil/Ibuprofen (age appropriate dose)			
Benedryll/diphenhydramine allergy			
Cortisone ointment			
Antibacterial ointment			
Tums for upset stomach			

_____ _____

Parent signature Date

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