



# BOLLES

Boarder Medical Information and Authorization

STUDENTS MAY NOT ATTEND SCHOOL WITHOUT THIS FORM ON FILE

**This form must be filled out each year. Last year's form is not valid.**

STUDENT'S NAME \_\_\_\_\_ Grade \_\_\_\_\_

\_\_\_\_\_ *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *Middle*

Preferred Name \_\_\_\_\_  Male  Female

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

**PARENT INFORMATION:** *Please place an asterisk next to the first phone number we should call.*

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Work#: \_\_\_\_\_ Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ E-mail: \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Work#: \_\_\_\_\_ Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ E-mail: \_\_\_\_\_

Legal Guardian: (*Student lives with*) \_\_\_\_\_ Contact Number: \_\_\_\_\_

**EMERGENCY CONTACT:** (*to be used ONLY if parents or guardian cannot be reached*)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work#: \_\_\_\_\_ Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_

**MEDICAL INSURANCE** (*We provide International students with insurance*):

Name of Insurance Company \_\_\_\_\_

Claims Address \_\_\_\_\_

ID/Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Full Name \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Policyholder's Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Does the insurance company require pre-authorization?  Yes  No Telephone# \_\_\_\_\_

Does your child have Prescription Coverage?  Yes  No

Please attach a copy of your insurance and prescription card. (*front and back please*)

The Bolles School is required by HIPAA (the Federal Health Insurance Portability and Accountability Act) to preserve the privacy of your child's health information. In accordance with this policy, access to all student health forms is limited to the School nurse or administrative staff, and is only utilized for the safety and protection of your child or in an emergency.

*I authorize the School nurse or the faculty/staff of The Bolles School to obtain such professional medical/surgical care or hospital services as may appear to be necessary or desirable for the protection of the health or life of my minor child, named above. Any person rendering health care pursuant to this authorization shall be entitled to treat this consent as having been given to such person. I further understand that The Bolles School will, in any event where emergency room or hospital treatment for a student is indicated, use due and prompt diligence to notify and consult with a parent or guardian. I further agree to pay and to hold The Bolles School harmless on account of any reasonable medical, dental, hospital, or other related charges incurred on behalf of the patient.*

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:**

Student's name \_\_\_\_\_

Please list & explain all allergies (i.e., medication, environmental, insects, food ). \_\_\_\_\_

\_\_\_\_\_

Please indicate any special needs or conditions of which we should be aware: \_\_\_\_\_

\_\_\_\_\_

Please list any prescription or over-the-counter medication your child takes on a regular basis: \_\_\_\_\_

\_\_\_\_\_

Has student ever been hospitalized or had surgery? Please explain. \_\_\_\_\_

\_\_\_\_\_

Has student now or ever had any of the problems listed below?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Recurrent colds/Sinusitis   | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Ankle Injury/problem |
| <input type="checkbox"/> Mononucleosis               | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Knee Injury/problem  |
| <input type="checkbox"/> Abnormal Bleeding           | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Kidney Infection    | <input type="checkbox"/> Head/Neck Injury     |
| <input type="checkbox"/> Chickenpox                  | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Back problems        |
| <input type="checkbox"/> Nose/throat Problems        | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Skin Problems        |
| <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Diagnosed Migraines | <input type="checkbox"/> Eating Disorder      |

If yes to any, please explain giving dates, if applicable.

\_\_\_\_\_

Has student been in counseling with a psychiatrist, psychologist, or other counselor?  Yes  No

Reason for counseling: \_\_\_\_\_

Is this student currently in counseling?  Yes  No

**MENSTRUAL HISTORY:**

Age of onset \_\_\_\_\_ Medication taken for cramps? \_\_\_\_\_

Irregular periods  Yes  No Excessive flow  Yes  No Severe cramps  Yes  No

**EYE CARE:** Student wears glasses  Yes  No Contact Lenses  Yes  No

*Regular glasses should be supplied even if student uses contact lenses, and students who wear glasses should have two pairs, or a current prescription for glasses.*

**DENTAL CARE:** What was the date of student's last dental checkup? \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone#: \_\_\_\_\_

Does your child have Dental Insurance?  Yes  No If yes, please send a copy of the insurance card.

**ORTHODONTICS:** Student wears braces  Yes  No Retainer  Yes  No

Will follow-up care be required while the student is at Bolles?  Yes  No

Orthodontist Name \_\_\_\_\_ Phone#: \_\_\_\_\_