VERITAS PREPARATORY ACADEMY

Student Medical History and Consent to Medical Treatment

Student Last Name	Student First Name	Student Middle Name

Do you now have, or have you ever had any of the following conditions? If so, please state when and who cared for you. (Please answer Yes or No to each question and explain all "Yes" answers fully on the back. If you are unsure, indicate this here as well.)

1 ____ FREQUENT HEADACHES
2 ____ FAINTING, DIZZINESS OR WEAKNESS
3 ____ EPILEPSY OR CONVULSIONS
4 ____ NUMBNESS OR TINGLING
5 ____ FREQUENT NOSEBLEEDS
6 ____ HEARING OR VISION PROBLEMS
7 ____ A.D.D. OR A.D.H.D. (Medication/Dosage and Schedule) ______________________________
8 ____ PNEUMONIA
9 ____ TUBERCULOSIS DISEASE OR ANY HISTORY OF A POSITIVE TB SKIN TEST
10 ___ RHEUMATIC FEVER
11 ___ SCARLET FEVER
12 ___ HEART PROBLEMS OR HEART MURMUR
13 ___ HIGH BLOOD PRESSURE
14 ___ ARTHRITIS
15 ___ DIABETES- Type I _____ Type II _____
16 ___ ABNORMAL BLEEDING TENDENCIES
17 ___ ANEMIA
18 ___ THYROID DISORDERS OR MEDICATION
19 ___ SKIN DISORDERS OR RASHES
20 ___ ASTHMA OR ON CURRENT OR PAST ASTHMA MEDICATION
21 ___ LOSS OR IMPAIRMENT OF KIDNEY, EYE, OR LUNG
22 ___ HEPATITIS OR JAUNDICE
23 ___ INFECTIOUS MONONUCLEOSIS
24 ___ IRRITABLE BOWEL DISORDER
25 ___ BOWEL CRAMPS OR UPSET STOMACH
26 ___ STOMACH ULCERS (or on medication for treatment of)
27 ___ KIDNEY OR BLADDER PROBLEMS
28 ___ ALLERGIES TO ANY FOODS
29 ___ PEANUT ALLERGY
30 ___ ALLERGY TO PRODUCTS MADE FROM NUTS
31 ___ ALLERGIES TO ANY MEDICATION
32 ___ ALLERGY TO INSECT BITES OR BEE STINGS
33 ___ PREVIOUS FRACTURES OR DISLOCATIONS OF ANY BONE
34 ___ RESTRICTION FROM ACTIVITIES WITHIN THE PAST 5 YEARS (More than one week)
35 ___ HISTORY OF MUSCLE OR JOINTS PROBLEMS
36 ___ HISTORY OF KNEE PROBLEMS OR INJURIES

VERITAS PREPARATORY ACADEMY

37 ___ HISTORY OF BACK OR NECK PROBLEMS
38 ___ HISTORY OF SCOLIOSIS
39 ___ CHICKENPOX (Age _________)
40 ___ SURGERIES (If yes, what type of surgery and when on reverse side):
USING THE QUESTION NUMBER, PLEASE EXPLAIN IN DETAIL ANY "YES" RESPONSES ON THE SPA PROVIDED BELOW.

The school reserves the right to use the closest hospital or medical facility in order to provide prompt attentic to your son at the time of emergency unless noted above. Emergency personnel have the final decision regarding transport.

EMERGENCY MEDICAL CONSENT

I/We, the undersigned parent(s), do hereby authorize officials of Veritas to obtain any necessary emergency medical treatment for my child in the event I/we cannot be reached immediately. In the event physicians, oth persons named on this card, or parents cannot be contacted, the school official responsible at the time of th emergency is hereby authorized to take whatever action is deemed necessary in the judgment of profession medical personnel, for the health and safety of my child. I/We will not hold the school or any school employe or officer financially responsible for the emergency care and/or transportation of my child for emergency car

Parent/Guardian Signature

By signing, the undersigned agrees to the terms and conditions as outlined. Included and attached is copy of the student's medical card.

Student Name ______________________________

Guardian Name ______________________________

Guardian Signature ______________________ Date: ______________

VERITAS PREPARATORY ACADEMY

IS STUDENT CURRENTLY TAKING ANY MEDICATION OR BEING TREATED FOR ANY HEALTH PROBLEM OR ONGOING CONDITION? Y / N

If yes, please explain fully:

____

____

____

____

____

____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS OR WRITE N.K.A.:

____

____

____

____

____

Examiner Name and Title ______________________________

Examiner Signature ____________________ Date: ____________