

Medical Information

for Dublin Christian Academy

* A MEDICAL FORM IS REQUIRED FOR EACH STUDENT



form **DU-31**

Student Information

Name	Gender	Birthdate
Social Security Number (Student)	Age	Current Grade
Student's Physician	Telephone	
Student's Dentist	Telephone	
Student Resides with: <input type="radio"/> Both Parents <input type="radio"/> Father <input type="radio"/> Mother <input type="radio"/> Other	Parents' Email	

Parents Information

Father	Work Phone	Home Phone	Cell Phone
Address	City	State	Zip
Mother	Work Phone	Home Phone	Cell Phone
Address	City	State	Zip

Check (x) if student has HAD any of the following:

PLEASE EXPLAIN ANY (X) CONDITIONS ON THE BACK

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Operations | <input type="checkbox"/> Malaria | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Physical handicap | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Concussion or head injury | <input type="checkbox"/> Fractures | <input type="checkbox"/> Allergies- to what | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Ear trouble | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing loss or defect | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Emotional problems |

Other medical questions

- Is there any other medical information which you feel we should have about this student? Is the student on any medications? Please Specify

- Date of last tetanus shot _____
- Family History- Briefly explain any family history (including parents, grandparents, uncles, aunts, brothers and sisters) of the following:
 - Allergies _____
 - Diabetes _____
 - Cardiac Problems _____
 - Other _____



P: (603) 563-8505
F: (603) 563-8008

106 Page Road, Dublin, NH 03444
dca@dublinchristian.org

Visit us online at
www.dublinchristian.org

Dublin Christian Academy admits students of any race, color, nationality, or ethnic origin.

Current Insurance Information IF NONE, WRITE "NONE".

1. Insurance Company _____
2. Insurance Address _____ City _____ State _____ Zip _____
3. Policy Number _____
4. Subscriber _____
5. Employer _____
6. Employer Address _____ City _____ State _____ Zip _____
7. Notification Required Yes No If Yes, telephone # _____

Authorizations

A. Dublin Christian Academy is authorized carry out accepted health procedures for my child and act in my behalf for medical or surgical services deemed necessary to protect the welfare of the same. I give permission for information to be released, if necessary, regarding my child's health situation to administrative authorites, appropriate staff and faculty, health care providers and institutions, pharmacies and my health insurance company.

B. Dublin Christian Academy is authorized to administer prescription and non-prescription medications as needed to my child.

C. Financial Responsibility

When not covered or paid through medical insurance coverage, I accept full responsibility for all medical expenses including doctors' fees, hospital fees, and medicines wihile my child is in attendance at Dublin Christian Academy.

D. The following people may be notified in case of emergency and give appropriate information regarding my child's health situation.

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

E. Release of information may be done using fax, e-mail, telephone, postal service, or in person.

I hearby agree to all of the above authorizations.

Signature of parent or Guardian _____ Date _____

Student (over 18) _____ Date _____

Explanations from Side #1

