

Student Medical History

Perpich Center for Arts Education 2009-2010

 Last Name First Name Middle Name Date of Birth

Class Entering (circle): 11 12 Resident/Commuter

 Home Address City State Zip

 Parent/Guardian Name E-mail Address

 Area Code/Home Phone # Mother's Cell # Father's Cell #

 Name of person to contact in case of emergency if parents/guardian cannot be reached.

 Relationship to Student

 Address City State Zip Phone #

FAMILY AND PERSONAL HEALTH HISTORY

The following health history is confidential, does not affect your admission status, and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

A. Do you have any drug allergies? Yes No If yes, describe type of reaction. _____

B. Do you have any food allergies? Yes No If yes, give date tested, describe allergy and treatment needed.

C. Do you have other types of allergies (e.g., ragweed, latex, etc.)? Yes No If yes, please describe. _____

D. Do you have an EpiPen? Yes No EpiPen required for all food allergies unless exempt by physician. Please provide documentation and bring TWO EpiPens to campus with you.

E. Has any blood relative (mother, father, siblings, or grandparents) had the following?

Condition	Y	N	Relationship	Condition	Y	N	Relationship
High Blood Pressure				Diabetes			
Stroke				Glaucoma			
Cancer (Type & Age)				Blood Clotting Disorder			
Heart Attack (age)				Drug/Alcohol Problems			
High Cholesterol				Psychiatric Illness/Suicide Attempt			
Sudden Death (age)				Bleeding Disorder			
Kidney Disease				Seizures			
Asthma							

(over)

F. Please list any drugs (prescription and non prescription), vitamins, herbs, and birth control that you use.
 (Authorization forms must be submitted for all medications.)

H. Have you had any of the following? Check Y (yes) or N (No) and explain below. Attach additional paper if needed.

Problem	Y	N	Date(s) of occurrence or diagnosis	Is this condition ongoing?
1. Surgery (including same day)				
2. Breathing difficulty with exercise				
3. Serious illness, injury, broken bones				
4. Diabetes (specify type)				
5. Seizures				
6. Asthma				
7. Been hospitalized overnight				

I. Explain all Yes answers here and identify problem by number. Please be specific.

J. Other than a routine physical, have you seen a physician or health professional in the past 6 months? Yes No
 If yes, please explain. _____

K. Has your academic career ever been interrupted due to a physical or emotional problem? Yes No
 If yes, please explain. _____

L. Have you ever been treated or received counseling for anxiety, depression, eating disorder, attention problems, or any other psychiatric illness? Yes No If yes, please explain. _____

MEDICAL ATTENTION AUTHORIZATION

In case of illness or injury requiring medical attention involving my child while the child is in attendance at the Center or within the custody of the Center or within the custody of its employees; I hereby authorize a Center representative to act in my behalf until I can be reached through the emergency contacts provided. Furthermore, in the event of a medical emergency, I authorize the Center to take my child and this medical history form to any health care professional or hospital licensed under the provisions of the State of Minnesota. I authorize any selected medical professional to proceed with any medical treatment deemed necessary until I can be reached. I understand I am fully responsible for all expenses incurred for any medical attention received by my child.

STUDENT/PARENT STATEMENT

- I attest that the provided medical information is true and complete to the best of my knowledge.
- I will notify the school nurse of any new health conditions or medication my child/I may have during the 2009-2010 school year. Keeping staff updated helps in planning for any medical needs and the safety of our school environment.

Signature of Parent/Guardian _____ Date _____

Signature of Student _____ Date _____

Questions? (763) 591-4838 or (800) 657-3515 FAX (763) 591-4717

RETURN BY June 19, 2009

ATTN: Nancy Killian RN, PHN, Licensed School Nurse, PERPICH CENTER FOR ARTS EDUCATION
 6125 Olson Memorial Highway, Golden Valley, MN 55422 4/09