MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

HEALTH INFORMATION AND MEDICAL TREATMENT FORM

STUDENT INFORMATION:

Student Name: _______________________________________ Goes by: __________________________
Last First Middle

Social Security #: _______________________Gender: _______Grade: ______ DOB: _______________

SPECIAL NEEDS:

1. **EMOTIONAL/PSYCHOLOGICAL**

Has the student ever had any emotional or psychological problems requiring counseling or treatment?

☐ YES ☐ NO

If "YES", a letter from the student's physician and/or psychiatric or psychological counselor must be submitted to the Director for Student Affairs explaining the nature of the concern, describing its current status, and offering professional suggestions regarding the student's adaptation to the school setting. This communication is considered confidential and privileged information.

2. **PHYSICAL/EDUCATIONAL**

Does the student have a handicapping condition? ☐ YES ☐ NO If yes, what is the handicapping condition?

____

____

____

What special attention has this condition required? _______________________________________

____

____

GENERAL HEALTH INFORMATION

1. What is your student's normal body temperature? ____
2. Please list allergies:

Food: ____

Medication: ____

Environmental: ____

Animals/Insects: ____

Does your child carry an Epi-Pen? ☐ YES ☐ NO

Does your child require allergy shots, Benadryl, or other allergy medication? ☐ YES ☐ NO

(If YES, describe) ____

3. Does your child have asthma? ☐ YES ☐ NO

   If "YES", does he/she carry an inhaler? ☐ YES ☐ NO

4. Does your child have a history of migraines? ☐ YES ☐ NO If "YES":

   How frequently do they occur and what is their duration? ______________________________

   Medication taken: ____

   Other treatment: ____

   Have the migraines resulted in classes being missed? ☐ YES ☐ NO

5. Females only:

   Irregular Periods ☐ YES ☐ NO
   Severe Cramps ☐ YES ☐ NO
   Excessive Flow ☐ YES ☐ NO
   Has resulted in classes being missed ☐ YES ☐ NO
   Medication taken: ____

6. Does the student require a special diet? ☐ YES ☐ NO If "YES", explain:

   ____

   ____

7. Will the student's present physical condition prevent participation in any activities?

   ☐ YES ☐ NO If yes, explain: ____

   ____

   ____

8. Does the student have any illnesses or ongoing medical condition which requires treatment that will need to be continued while at MSMS?

   ☐ YES ☐ NO If yes, explain: ____

   ____

9. Does the student take prescribed medication regularly?

   ☐ YES ☐ NO If yes, explain: ____

   ____

MEDICATION

ALL prescribed medications must be registered with the Residence Hall Director; certain prescribed medications must be kept and administered by authorized school personnel (see handbook).

- **The Residence Hall General Medication Use Form** (attached) governs over-the-counter medications which may be dispensed to your child.
- The **Prescription Medication Authorization Form** (attached) is a general form that governs the storage and use of prescription medications by your child. Please keep blank copies of this form at home as it has a section that must be completed by the prescribing physician or nurse practitioner each time a new prescription is written that will be brought to campus.

Is there anything else we should know to ensure the health and wellness of your child? __________________

____

____

____

MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

My son/daughter is a military dependent and is to be treated at CAFB: ☐ YES ☐ NO

STUDENT PHYSICIAN/INSURANCE INFORMATION:

Enclose a copy of all insurance cards, both front & back. ***Do not Staple or Tape.***

Physician's Name: ______________________________________ Phone #: (____) ________________

Dentist's Name: ____ Phone #: (____) ________________

Orthodontist's Name: ____________________________________ Phone #: (____) ________________

Ophthalmologist/Optometrist Name _________________________________ Phone#: (____) ________________

Does the student have health/medical insurance? ☐ YES ☐ NO

Does the student have prescription drug coverage? ☐ YES ☐ NO

Does the student have dental insurance? ☐ YES ☐ NO

Does the student carry his/her own insurance card(s)? ☐ YES ☐ NO

Name of Insurance Company: ____

Insurance Company Address: ____
Street City State Zip

Insurance Company Phone: _____________________________ Fax: _________________________________

Policy Holder's Name: _____________________________________ Date of Birth: _________________

Place of Employment: ____

Relationship to Student: ____

ID#: ________________________ Group #: ______________________ Policy #: ________________________

Please mark all that apply:

☐ Student does not wear glasses or contact lenses (remainder of form should remain blank)

☐ Student wears glasses.

☐ Student wears contact lenses.

We recommend that students wearing glasses and/or contact lenses have their annual eye examination before coming to school in the fall. Students wearing contact lenses should also have a current pair of glasses for those situations that could preclude wearing contacts. Include with this form a copy of your child's current eye exam including current prescription for glasses or contacts if worn.

I understand that I am responsible for all medical fees incurred while in attendance at the Mississippi School for Mathematics and Science. Also, I understand that transportation will be provided in case of illness or emergency. **All regular and wellness appointments should be made during times at home with your regular doctor.** I have answered all the above questions accurately and honestly to the best of my knowledge.

____ ____ _____________

Parent/Guardian printed name Parent/Guardian Signature Date