Truman State University-JBA Jr.

Medical Information – Confidential

TO BE COMPLETED BY PARENT/GUARDIAN

Student's name:		**Social Security #**	
Address, City, Zip		Gender	Birth date
Father/Guardian:	Home phone:	Work/Cell phone:	
Mother/Guardian:	Home phone:	Work/Cell phone:	
Emergency Contact (other than parent/guardian):	Relationship to student:	Daytime phone:	Cell phone:
Family Physician name & address:		Telephone	

Immunization Information:	***You may attach a copy to this form***	
Tetanus or (Date of Last Booster)	Hepatitis B Series	
MMR (Series of 2) 1. 2.	DPT (series of 4) 1. 2. 3. 4.	Polio (series of 4) 1. 2. 3. 4.

Insurance Information:		
☐ We are uninsured at this time.		
☐ My Medical Insurance Provider is:	Policy/Group #:	Prescription card #:
Address of insurance company:	Insurance company's telephone:	
Date of Birth of policyholder:	Name of policy holder:	Employer of policy holder:

Please attach a copy (front/back) of your insurance card to this form.

Medications:

The Joseph Baldwin Academy will supply the following medications (or their generic) as needed for the symptoms indicated, and according to package directions. Check off those medications that your child can receive on an as-needed (PRN) basis:

☐ Advil for pain, headache or menstrual cramps	☐ Benadryl for allergy symptoms	☐ cough drops for sore throat
☐ Imodium for diarrhea	☐ Robitussin DM for cough	☐ Sudafed for sinus congestion
☐ Tums/Rolaids for stomach upset	☐ Tylenol for headache or pain	☐ Visine for eye irritation

Please do <u>not</u> give my child the following medications under any circumstances:

☐ My child does <u>not</u> take any medications at this time.

☐ My child takes prescription medication(s) (please list on next page). I understand that any medications (including prescription medications and over-the-counter medicines) will be dispensed by the JBA staff only, and that my child may not keep any medication with him or her (with the exception of asthma inhalers, insulin, EpiPens, and topical medications). I understand that all medications must be in their original containers and will be given according to physician or package directions.

Allergies to medications, food, insect bites, etc.

Does your child carry an EpiPen for allergies? ☐ Yes ☐ No

Please list any prescription medication(s) your student takes, what the medication is for, how it should be dispensed, any special instructions, supplies or equipment used to administer the medication and when he/she should take the medication.

Medication Taken for:	Dose	Time (circle as many as apply) Breakfast, lunch, 3 pm, dinner, bedtime, as needed, mandatory
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NOTE: If it is **mandatory** that this medication be taken at the time indicated, circle "mandatory". This is recommended for medications that, if missed, could pose serious risk (heart medication, basal insulin, etc.) If this column is checked, students will be made to take the medication and be subject to disciplinary action for missing doses. Do not circle "mandatory" if it is not mandatory that your child take the medication at the time indicated above. Do not circle "mandatory" on medications for which missed doses pose little or no threat to the student. If "mandatory" is not circled, the JBA staff will ignore missed doses.

☐ I understand by not circling "mandatory" I am releasing the staff of the Joseph Baldwin Academy, Truman State University and/or any off campus medical facility from liability due to missed or discontinued use of prescription medication.

Medical History: Please give your child's full medical history below. This information will be necessary in the event that your child needs emergency medical treatment. Check if there is a history of a problem or condition and give details in the space provided:

☐ ADD or ADHD	☐ Eating disorder	☐ Learning disability
☐ Asthma (carries inhaler ☐)	☐ Eczema/skin disorder	☐ Migraines/headaches
☐ Bronchitis/pneumonia	☐ Epilepsy/Fainting/Seizures	☐ Mononucleosis
☐ Chicken pox	☐ Gastrointestinal disorders	☐ Musculoskeletal disorders
☐ Depression/anxiety	☐ Hearing/vision impairment	☐ Neurological disorder
☐ Developmental disorders (e.g., Asperger's PDD-NOS)	☐ Heart defect/disease	☐ Other
☐ Diabetes	☐ Hemophilia/anemia/blood disorder	
☐ Ear/sinus infections	☐ High blood pressure	

Details of conditions checked above (feel free to attach additional documentation if needed):

History of operations or serious illness:

Is your child under the care of a psychologist, psychiatrist, or counselor? If so, please give contact information:

Special Dietary Needs: ☐ Vegan ☐ Vegetarian ☐ Other

Consent for Treatment of a Minor:

This is to authorize the staff of the Joseph Baldwin Academy and/or off-campus medical facilities to provide necessary medical care to my child. The information I have provided on this form is accurate and complete. A photocopy of this form shall serve in the same capacity as the original document.

I give permission for the staff of the Joseph Baldwin Academy or physicians of the nearest or most appropriate hospital, to provide routine health care; to administer medications; to order x-rays, tests, or treatment; to release any records necessary for insurance purposes; and to arrange necessary transportation for my child. In the event that I cannot be reached in an emergency, I give permission for the physician selected by the Joseph Baldwin Academy to secure and administer treatment, including surgery or hospitalization, for the student named above. I give permission for the Joseph Baldwin Academy to contact my child's medical provider for the purpose of confirming medical conditions/treatments or obtaining additional information in order to provide appropriate care. This authorization shall be in effect while my child is a student in the Joseph Baldwin Academy.

I understand that I am fully responsible for all medical costs incurred by my child.

Signature of parent/guardian:	**Date:**

(rev 2/18)