

# The Long Island High School for the Arts - Nassau BOCES

## PARENT MEDICAL INFORMATION FORM

STUDENT NAME: \_\_\_\_\_ GRADE 2021-2022 \_\_\_\_\_

**TO BE COMPLETED ANNUALLY BY THE PARENT OR GUARDIAN**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Gender Identity (optional): \_\_\_\_\_ Sex at Birth: \_\_\_\_\_ Prounouns (optional): \_\_\_\_\_

Home Phone: \_\_\_\_\_

Parent/Guardian 1: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Authorized Emergency Contact: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Student's Doctor: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Telephone: \_\_\_\_\_ Fax #: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

I, \_\_\_\_\_, am the parent/legal guardian of \_\_\_\_\_, who was born on \_\_\_\_\_ and who resides at \_\_\_\_\_.

\_\_\_\_\_ I authorize a faculty member of The Long Island High School for the Arts to consent to any emergency treatment which may be necessary for my child named above in case of illness or injury after efforts to contact me are unsuccessful. Such treatment may include, but is not limited to, examina-tion, x-rays, laboratory tests, medical and surgical treatment, use of medication, anesthesia and/or sutures as well as admission for hospital care as may be required. I understand that such care will be based upon medical advice. day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

**STUDENT'S HEALTH HISTORY: MUST BE COMPLETELY FILLED OUT BY PARENT / GUARDIAN**

*Please check YES or NO to the following questions. If you answer yes to any questions explain below.*

- |  | YES                      | NO                       |  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Does the student have allergies?<br><i>List: _____</i>  | <input type="checkbox"/> | <input type="checkbox"/> | 9. Has any family member or relative died of a heart problem, heart attack, stroke or a sudden unexplained death before the age of 50?<br><i>If YES, explain: _____</i>          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the student take any daily medications?<br><i>List: _____</i>  | <input type="checkbox"/> | <input type="checkbox"/> | 10. Has a doctor ever ordered a test for the student's heart (i.e. echo, stress test)?<br><i>Type of Test: _____ When: _____</i>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the student have any ongoing medical conditions (i.e. seizures, diabetes, asthma, ADHD)?<br><i>List: _____</i>                                     | <input type="checkbox"/> | <input type="checkbox"/> | 11. Does anyone in the student's family have Marfan's syndrome, hypertrophic cardiomyopathy, long QT syndrome, or other cardiomyopathy?<br><i>If YES, explain: _____</i>         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the student cough, wheeze or have difficulty breathing DURING or IMMEDIATELY AFTER exercise?<br><i>List: _____</i>                                 | <input type="checkbox"/> | <input type="checkbox"/> | 12. Was the student born without or is missing a kidney, eye, testicle or any other organ?<br><i>List: _____</i>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the student ever had surgery or been hospitalized overnight?<br><i>If YES, explain: _____</i>   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Has the student ever had a concussion or serious head injury? <i>If yes, explain: _____</i>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the student ever passed out or nearly passed out DURING exercise? <i>If yes, explain: _____</i>   | <input type="checkbox"/> | <input type="checkbox"/> | 14. Has the student ever been hit in the head and been confused, lost memory after the injury or been unable to move arms or legs or felt weak?<br><i>If yes, explain: _____</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the student ever had pain/discomfort or pressure in chest DURING exercise?<br><i>If YES, explain: _____</i>   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 8. Has a doctor ever said the student has a heart murmur, heart problem, high blood pressure, high cholesterol or a heart infection?<br><i>List: _____</i> | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

\_\_\_\_\_  
Signature of Parent or Legal Guardian