



academy of fine arts

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Student Medical Form

(Please Print Clearly)

(To be updated as needed or at least once/year) **Date Provided:** _____

Students Last Name

Students First Name

Date of Birth

Height:

Weight

Hair

Parent/Guardian (Primary Contact):

Name: _____

Relationship to Student: _____

Daytime Phone: _____ Evening phone: _____

Cell Phone: _____

In the event that the above cannot be reached, please designate a second Emergency Contact:

Name: _____

Relationship to Student: _____

Daytime Phone: _____ Evening phone: _____

Cell Phone: _____

MEDICAL INFORMATION:

Dr. Name: _____

Dr. Phone Number: _____

Hospital Preference: _____

Name and Policy Number of Medical Insurance Carrier:

Name of Medical Insurance Carrier: _____

Policy Number: _____

Does Student have allergies to any of the following (**Please check all that apply**):

Latex Nuts Dairy Bee/Insect Stings

Other (including medications):

Please List "Other"

Please explain (including allergic reaction and treatment)

Any special dietary restrictions? NO YES **If Yes, Please List:**

Does Student carry an epipen: NO YES **If Yes...**

Can Student self administer it if needed? NO YES

Has Student ever needed it? NO YES

Please note that Student will immediately be taken to a medical facility and parent/guardians will be notified if an epipen is used

I grant that, if necessary, appointed supervising PHAME staff can administer the following to the above named Student if/as needed: (Please check all that apply):

Tylenol Ibuprofen Aspirin

Does Student have a history of seizures/epilepsy within the last 5 years?

NO YES **If YES, complete Seizure Protocol Form**

Does Student have asthma? NO YES

If YES, does Student use an inhaler? NO YES

(If YES, include the inhaler under list of medications below.)

Does Student have any other recurring or chronic health issues?

NO YES **If Yes, please explain:**

List any medications that Student takes regularly (including both prescription and over the counter medications), along with the dosage, time taken, what the medication is for, any side effects, and anything else about the medication/dosage we need to know for safe administration (IE: if Student takes medication crushed up and mixed in applesauce, pudding, etc. please indicate this and provide the appropriate amount to be taken with the medication)

Medication	Dosage/ Time Taken	For	Side Effect(s)	Other
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any activities that should be avoided, limited, or that require special supervision for this Student:

Optional Information: (Any Other Information you would like us to know)

The information on this Student Medical Form is true and accurate to the best of my knowledge:

Parent/Guardian (Primary Contact)

Signature: _____ **Date:** _____

Printed Name: _____

Student Signature: _____ **Date:** _____

Printed Name: _____