NEW YORK MILITARY ACADEMY

Cornwall-on-Hudson, New York 12520
(914) 534-3710, ext. 236

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

All of the information on this form is confidential and will be used only for the purpose of evaluating your daughter's/son's health status and facilitating medical diagnosis, care, and/or treatment for her/him or in the processing of insurance claims in connection therewith.

STUDENT'S Name _____ Date of Birth _____ / _____ / _____
Last First MI

Home Address _____

EMERGENCY CONTACTS

Mother's Name _____ Father's Name _____

Home Phone (___) _____ Home Phone (___) _____

Work Phone (___) _____ Work Phone (___) _____

Alternate Emergency Contact (other than parent(s) _____

Relation _____ Home Phone (___) _____ Work Phone (___) _____

PRIMARY CARE PHYSICIAN

Physician Name _____ Phone (___) _____

Date of last physical examination _____ /_____ /_____

MEDICAL INFORMATION

Last Tetanus _____ /_____ /_____

		Check if Yes
Allergies _____ _____	Asthma Diabetes Epilepsy	☐ ☐ ☐
Medication	Head Injury Recurrent Headache Sinustitis Rheumatic Fever or Heart Murmur	☐ ☐ ☐ ☐
Medical Conditions & Surgeries	Hernia Varicolele ( ) Scoliosis Anemia	☐ ☐ ☐ ☐

PSYCHOLOGICAL INFORMATION

Has student ever received counseling or presently receiving counseling? ☐ YES ☐ NO
If yes, attach letter stating condition and progress in detail including medications.

INSURANCE INFORMATION

PHOTOCOPY OF INSURANCE CARD **MUST** BE INCLUDED

PERMISSION TO TREAT & TO RELEASE SUMMARY HEALTH FORM IN EMERGENCIES

I hereby give consent for the Medical Staff of New York Military Academy to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment or counseling for my (son/daughter, ward). Should an emergency arise in which time is an important factor and the school authorities are unable to contact me promptly, I authorize the school physician, Headmaster, a school official and/or Cornwall Hospital to exercise their best judgement in the interests of my child's welfare.

I also give permission for this Summary Health Form to be released to those Student Health Services personnel or other appropriate health care providers who may need this information in order to treat my son/daughter/ward in a medical emergency.

Signature of Parent or Guardian_____Date _____/ _____/ _____

HEALTH FORM

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Cornwall-on-Hudson, New York 12520

PHYSICIAN EXAMINATION

TO THE EXAMINING PHYSICIAN: The state of New York requires all students to present evidence of immunization against measles, mumps, rubella, hepatitis B, Diphtheria and tetanus in order to register for classes. Please comment on all positive answers. The information supplied will be used as background for providing health care, if necessary. This information is strictly for the use of Health Services and will not be released without the student's consent.

Name _____
Last First MI

Blood Pressure (sitting) _____Height _____ft. ____in. ____Weight _____lbs. Corrected Vision: Right 20/ ____Left 20/_____

URINALYSIS

Sugar _____
Albumin _____
Micro _____

HEMOGLOBIN

_____gms/%
Date _____/ ___/ ____
Result _____

Immunization Record (mo/day/yr)	1	2	3	4	5	Date Last Done
Diphtheria, Tetanus Pertussia						
Diphtheria, Tetanus						
Polio Oral						
Hepatitis B			Tuberculin skin test: date _____			
Measles			Result: negative _____			
Mumps			positive _____			
Rubella			If + attach copy of X-ray			

Are there any abnormalities of the following systems?

System	Yes	No	If yes, please describe
1. Head, Ears, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes, other than Acuity			
7. Gerdito urinary + tanner			
8. Musculoskelatal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Teeth			
13. Menstrual			

Is there loss or seriously impaired function of any organ? YES ☐ NO ☐

Have you any general comments?_____

_____

Recommendations for physical activity (Phys Ed. Intramurals) Unlimited ☐ Limited ☐ _____

Do you have recommendations regarding the care of this student? YES ☐ NO ☐_____

Is the patient now under treatment for any medical or emotional condition YES ☐ NO ☐_____

Is there a history of learning disability? YES ☐ NO ☐ _____

PHYSICIAN'S SIGNATURE_____Date _____/ _____/_____

Address_____

M. D. Stamp