## Student Health Record-FILL OUT ONLY 1 PER STUDENT/ SUMMER

## Form A—DOES NOT REQUIRE A DOCTOR'S SIGNATURE

Westfield State University 577 Western Avenue Westfield MA 01086-1630 (413) 572-8557 Fax: (413) 572-5227

Clird State Zip Code: City/State Zip Code: School: Parent's Name(s) Home Address Home Phone Work Address Work Phone  If not available in an emergency notify:  1. Name Address Phone 2. Name Address Phone 2. Name Address Phone MEDICAL HISTORY:  YES NO Anemia Gastro Intestinal problems Surgery Ashma Head Injury Appendectomy Blood Transfusion Head Injury Appendectomy Blood Transfusion Heading Deficit Haming Deficit Dispersion Heading Deficit Dispersion	To be filled out by parent or	<b>A</b>		Data a CD'	at.							
Trome Address   Home Phone   Work Address   Work Phone      Parent/Guardian Information:	Child's Name:						Age: Date of Birth:					
School: Parent/Suame(s) Home Address Home Phone Work Address Work Phone  If not available in an emergency notify:  1. Name Address Phone 2. Name Address Phone MEDICAL HISTORY:  YES NO Anemia Address Phone MEDICAL HISTORY:  YES NO Anemia Agreement Phone Address Phone MEDICAL HISTORY:  YES NO Anemia Agreement Phone Phone Phone Phone MEDICAL HISTORY:  YES NO Anemia Agreement Phone Phone Phone Phone MEDICAL HISTORY:  YES NO Anemia Agreement Phone Pho	Home Address:					Pnone	e:					
Parent's Name(s)   Home Address   Home Phone   Work Address   Work Phone	School:											
Parent's Name(s)   Home Address   Home Phone   Work Address   Work Phone	Parent/Guardian Information											
If not available in an emergency notify:   1. Name		Home Address			Home Phone		Work Address		Work Phone			
1. Name Address Phone 2. Name Address Phone  MEDICAL HISTORY:    YES   No	Tarent s Name(s)	Home Address			110me 1 none		VV ULK AUULESS		WOLK Flidle			
1. Name Address Phone 2. Name Address Phone  MEDICAL HISTORY:    YES   No												
1. Name Address Phone 2. Name Address Phone  MEDICAL HISTORY:    YES   No												
1. Name Address Phone 2. Name Address Phone  MEDICAL HISTORY:    YES   No												
Name Address Phone    Name Address Phone   Address Phone   Address   Phone   Address   Phone												
Name   Address   Phone	Name			Addr	ress			P	hone			
MEDICAL HISTORY:   Anemia				Addr	ress			p	hone			
Anemia   Gastro Intestinal problems   Surgery   Appendectomy   Back Injury/Problem   Head Injury   Appendectomy   Back Injury/Problem   Headaches (recurrent)   Tonsillectomy   Discussion   Hearing Deficit   Thyroid Disease   Chicken Pox   Heart Murmur   Urinary Tract Infection   Contact Lenses   Hepatitis   Urinary Tract Infection   Discussion/Anxiety   High Blood Pressure   OTHER:   Disease/Injury of Joints/Bones   Learning disability   Disease/Injury of Joints/Bones   Disease/Injury of Joints/Bones   Learning disability   Disease/Injury of Joints/Bones   Learning disability   Disease/Injury of Joints/Bones   Disease/Injury of Joints/Bones				7 Iddi	1033				none			
Anemia   Gastro Intestinal problems   Surgery   Asthma   Head Injury   Appendectomy   Back Injury/Problem   Headaches (recurrent)   Tonsillectomy   Blood Transfusion   Hearing Deficit   Thyroid Disease   Chicken Pox   Heart Murmur   Urinary Tract Infection   Chicken Pox   Heart Murmur   Urinary Tract Infection   Contact Lenses   Hepatitis   Urinary Tract Infection   Contact Lenses   Urinary Tract Infection   Urinary Tract Infection   Contact Lenses   Urinary Tract Infection   Contact Lenses   Urinary Tract Infection   Urinary Tract Infection   Urinary Tract Infection   Contact Lense		YES	No			YES	No			YES	No	
Asthma Back Injury/Problem Blood Transfusion Chicar Pox Heart Murmur Urinary Tract Infection Contact Lenses Hepatitis Depression/Anxiety Bickney Problems Disease/Injury of Joints/Bones Ear, Nose, Throat Problems Ear, Nose, Throat Problems Back Injury of Joints/Bones Ear, Nose, Throat Problems Ear, Nose, Throat Problems Ear, Nose, Throat Problems Ear, Section S	Anemia			Gastro Intestin	nal problems			Surgery				
Back Injury/Problem	Asthma			_								
Blood Transfusion   Hearing Deficit   Thyroid Disease   Chicken Pox   Heart Murmur   Urinary Tract Infection   Chicken Pox   Hepatitis   Urinary Tract Infection   Contact Lenses   Hepatitis   Depression/Anxiety   High Blood Pressure   OTHER:   Disease/Injury of Joints/Bones   Learning disability   Disease/Injury of Joints/Bones   Learning disability   Ear, Nose, Throat Problems   Mononucleosis   Eating Disorders   Rheumatic Fever   Eye Problems   Seizures   Eye Problems   Seizures   Fainting   Strep Throat   Allergies: (please specify)   Chronic or recurring illness/diability:   Medications: Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date?   Yes	Back Injury/Problem											
Contact Lenses				Hearing Deficit				Thyroid Disease				
Depression/Anxiety   High Blood Pressure   OTHER:   Diabetes   Kidney Problems   Disease/Injury of Joints/Bones   Learning disability   Disease/Injury of Joints/Bones   Mononucleosis   Disease/Injury of Joints/Bones   Rheumatic Fever   Disease/Injury of Joints/Bones   Rheumatic Fever   Disease/Injury of Joints/Bones   Disease/In	Chicken Pox							Urinary Tract Infection				
Diabetes Disease/Injury of Joints/Bones Learning disability Ear, Nose, Throat Problems Mononucleosis Eating Disorders Bye Problems Seizures Fainting Strep Throat Allergies: (please specify)  Dietary Restrictions: (please specify)  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications: Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date? Yes No  Name of dentist: Phone:  Dispution of dentist: Phone:  Dispution of dentist: Phone:  Dispution of dentist: Phone:  Phone:	Contact Lenses			Hepatitis								
Disease/Injury of Joints/Bones  Ear, Nose, Throat Problems  Bating Disorders  Rheumatic Fever  Eye Problems  Seizures  Seizures  Seizures  Strep Throat  Allergies: (please specify)  Dietary Restrictions: (please specify)  Chronic or recurring illness/diability:  Medications:  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications:  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications:  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date?  Yes No  Name of dentist: Phone:  Do you carry family medical/hospital insurance? If so, indicate:  Carrier: Policy/Group #:  Any specific activities to be encouraged?  Any specific activities to be discouraged?  IMPORTANT: PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.  Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached in emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or surgery for my child as named above.	Depression/Anxiety			High Blood Pressure				OTHER:				
Ear, Nose, Throat Problems   Mononucleosis   Eating Disorders   Rheumatic Fever   Eye Problems   Seizures   Fainting   Strep Throat   Fainting   Strep Throat   Fainting   Strep Throat   Fainting   Strep Throat   Fainting   Fainting   Strep Throat   Fainting   Fain	Diabetes			Kidney Problems								
Eating Disorders  Eye Problems  Seizures  Seizures  Sirep Throat  Strep Throat  Dietary Restrictions: (please specify)  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date? Yes No  Name of dentist: Phone:	Disease/Injury of Joints/Bones			Learning disability								
Eye Problems   Seizures   Seizures   Strep Throat   Strep Throat				Mononucleosis								
Fainting Strep Throat  Allergies: (please specify)  Dietary Restrictions: (please specify)  Chronic or recurring illness/diability:  Medications:  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date?  Yes  No  Name of dentist:  Do you carry family medical/hospital insurance?  If so, indicate:  Carrier:  Any specific activities to be encouraged?  Any specific activities to be discouraged?  Any specific activities to be discouraged?  MPORTANT: PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.  Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached i an emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.	Eating Disorders			Rheumatic Fever								
Allergies: (please specify)  Dietary Restrictions: (please specify)  Chronic or recurring illness/diability:  Medications:  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date? Yes No  Name of dentist: Phone:  Name of pediatrician: If so, indicate:  Carrier: Policy/Group #:  Any specific activities to be encouraged?  Any specific activities to be discouraged?  MPORTANT: PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.  Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached i an emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.	Eye Problems			I .								
Dietary Restrictions: (please specify)				Strep Throat								
Chronic or recurring illness/diability:  Medications:  Parents/Guardians must make arrangements for the administration of medication. Staff will not be responsible for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date? Yes No  Name of dentist: Phone: _	<b>Allergies</b> : (please specify)											
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Medications:												
Parents/Guardians must make arrangements for the administration of medications. Please indicate how medication will be administered, if applicable:  Are your child's immunizations up to date? Yes No Name of dentist: Phone:		omity										
Are your child's immunizations up to date? Yes No Name of dentist: Phone: Phone: Do you carry family medical/hospital insurance? If so, indicate: Policy/Group #: Any specific activities to be encouraged? Any specific activities to be discouraged? Any specific activities to be discouraged? IMPORTANT: PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.  Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached in emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.	Parents/Guardians must make	arranger	ments fo	r the administra	tion of medication	n. Staff	will not b	e responsible for th	e adminisi	tration of		
Name of dentist:	medications. Please indicate h	ow medio	cation w	ill be administer	red, if applicable:							
Name of dentist:	Are your shild's immunications	un to do	+o?	Vac	No.							
Do you carry family medical/hospital insurance? If so, indicate:  Carrier: Policy/Group #:  Any specific activities to be encouraged?  Any specific activities to be discouraged?  EMPORTANT: PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.  Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached if an emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.	Name of dentist:	s up to da	te?	_ Yes	_ NO			Phor	ie.			
Do you carry family medical/hospital insurance? If so, indicate:  Carrier: Policy/Group #:  Any specific activities to be encouraged?  Any specific activities to be discouraged?  EMPORTANT: PLEASE NOTIFY THE COLLEGE FOR KIDS OFFICE IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM.  Parents' Authorization: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached if an emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.	Name of pediatrician:  Phone:											
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<b>DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY COLLEGE FOR KIDS PROGRAM. Parents' Authorization</b> : This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at Westfield State University and to be transported to the nearest hospital if College for Kids personnel deem it necessary. In the event that I cannot be reached i an emergency, I hereby give permission to the physician selected by the director to order x-rays, routine tests, treatment, hospitalization, injections, and/or anesthesia, and/or surgery for my child as named above.	Any specific activities to be end Any specific activities to be disc	couraged: couraged	? ?									
and/or anesthesia, and/or surgery for my child as named above.	<b>DISEASE DURING THE THE Parents' Authorization</b> : This I prescribed activities except as n State University and to be trans	REE WEI nealth his oted by r ported to	EKS PRI tory is come and the the near	OR TO ATTENA correct to the best the examining phy est hospital if Co	DANCE OR WHI tof my knowledge ysician. I give my ollege for Kids per	LE AT e, and the permisersonnel	TENDING e person h sion for m deem it ne	ANY COLLEGE F erein described has a y child to be given s cessary. In the even	OR KIDS permission simple first t that I can	PROGRA  n to engage t aid at We nnot be rea	e in all estfield ached in	
					by the director to	order x	-rays, rout	ne tests, treatment,	nospitaliza	uion, injec	cuons,	
Date.								Date:				