NOCCA Medical and Emergency Information

This form must be completed each year.
Students without a complete form will not be allowed to participate in their NOCCA classes.
It will be kept on-file in the NOCCA Health Services office.

Student Name _____ Art Discipline _____

Date of Birth _____ Age _____ Gender _____ Grade _____

Guardian 1

Name _____

Relationship to Student _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Guardian 2

Name _____

Relationship to Student _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Name of person (other than above) to contact in case of emergency _____

Relationship to Student _____ Phone Number _____

Health Insurance Information

Insurance Company _____

Address _____

Phone Number _____

Name of Policy Holder _____ Member ID Number _____

Type of Plan:

- ☐ Health Maintenance Organization (HMO)
- ☐ Preferred Provider Network (PPO)
- ☐ Standard Medical and Hospitalization Coverage
- ☐ Other _____

Health History

Has the student had any…? Check all that apply.

- ☐ Chronic or recurrent illness or injury?
- ☐ Illness lasting more than one week?
- ☐ Rheumatic fever, mononucleosis?
- ☐ Hospitalizations (overnight or longer)?
- ☐ Surgery, other than tonsillectomy?
- ☐ Missing organs (eye, kidney, testicles)?
- ☐ Allergy to medicine, insects, food?
- ☐ Seasonal allergies (hay fever)?
- ☐ Problems with heart, blood pressure, cholesterol?
- ☐ Racing of the heart or skipped heart beats?
- ☐ Chest pain with exercise?
- ☐ Frequent headaches, convulsions, dizziness, fainting?
- ☐ Dizziness or fainting with exercise?
- ☐ Concussions, unconsciousness, extremity numbness?
- ☐ Heat exhaustion, heat stroke, or other heat-related problems?
- ☐ Asthma?
- ☐ Epilepsy or other seizures?
- ☐ Diabetes?
- ☐ Eyeglasses or contact lenses?
- ☐ Dental braces, bridges, plates?
- ☐ Blood disorder?
- ☐ Injuries requiring medical treatment?
- ☐ Neck Injury?
- ☐ Knee Injury?
- ☐ Knee Surgery?
- ☐ Ankle Injury?
- ☐ Broken bones (fractures)?

Please explain all yes responses: _____

_____

_____

_____

Further History

Yes	No	
☐	☐	Has your child been diagnosed with ADD/ADHD?
☐	☐	Is there a history of family or genetic disease?
☐	☐	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
☐	☐	Has any family member had a heart attack at less than 55 years of age?
☐	☐	Is your child uncomfortably short of breath after running ½ mile (2 times around a track) without stopping?

List all medications your child is presently taking, including asthma inhalers, and the condition requiring the medication.

_____

_____

_____

If your child has a psychiatric diagnosis, takes medication for this, is in counseling or has been on counseling and/or drug rehabilitation, provide a letter from your child's psychiatrist or mental health professional indicating whether or not the child will be able to cope with the challenges of the specialized curriculum requirements offered at NOCCA.

Student Name: _____

Allergies

_____

_____

Medication List

The following medications are available for use in the conservative treatment of NOCCA students. Any additional prescriptions medications or extensive medical treatment shall be prescribed by a physician. YOU MUST SIGN this form in order for the following medications to be administered to your child by the Director of Health Services or other qualified NOCCA personnel. Any prescriptions or over the counter medication (excluding asthma inhaler) must be turned into the Director of Health Services when the student arrives on campus.

An authorized NOCCA employee may give my student the recommended daily dosage of:

Allergies/Sinus Congestion
☐ Benadryl
☐ Cold & Flu / Generic
☐ Cold & Sinus / Advil
☐ Sudafed

Cough
☐ Halls Cough Drops

Sore Throat
☐ Throat Lozenges / Generic

Nausea/Upset Stomach
☐ Tums / Generic
☐ Pepto Bismol / Generic

Pain
☐ Tylenol / Acetaminophen / Generic
☐ Motrin / Ibuprofen
☐ Advil / Generic

Skin Irritation
☐ Hydrocortisone 1% Cream
☐ Benadryl Topical

First Aid
☐ Hydrogen Peroxide
☐ Burn / Aloe Vera Gel
☐ Neosporin Ointment
☐ Bacitracin Ointment / Generic

Consent Agreement

I hereby authorize any medical treatment for my student that may be advised or recommended by NOCCA's Health Services staff or medical personnel to which he/she is referred. I agree to be responsible for the financial charges incurred as a result of these medical services not covered by my student's health insurance provider. I give permission for the Director of Health Services or other qualified NOCCA personnel to give first aid to my students in the even of injury, and to administer the medication indicated above, if warranted.

_____ _____
Parent/Guardian Name Parent/Guardian Signature

_____
Date