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 __________________________________

Allergies

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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 and epi pen) 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

Student Name: ____

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: ____

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Further History

Yes	**No**	
☐	☐	Has any family member had a heart attack at less than 50 years of age?

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

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IMPORTANT: If your student will need to take medication while at school, you must provide a State of Louisiana Medication Order for each medication. The prescribing physician can provide this form on request.

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 event of injury, and to administer the medication indicated above, if warranted.

____ ____
Parent/Guardian Name Parent/Guardian Signature

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Date