



St. Michael's Preparatory School

Health History Form

Applicant's Name: Last: _____ First: _____ Middle: _____

Birthdate: ____/____/____ Social Security Number: ____/____/____

Parent/Guardian Name: Last _____ First: _____

Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Email: _____

Address: _____ City: _____ ST: _____ Zip: _____

<p>Does student carry medical insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Does student carry dental insurance <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, please attach a copy of the card which provides the</p> <ul style="list-style-type: none"> Insurance Company Policy Number and Name of Policy Holder Address and Telephone Number of insurer 	<p style="text-align: center;">IMMUNIZATION HISTORY</p> <p>Please record dates (month/day/year) of these basic immunizations.</p> <p>Polio (OPV or IPV) _____/_____/_____, _____/_____/_____, _____/_____/_____</p> <p>Diphtheria <input type="checkbox"/> _____/_____/_____</p> <p>Tetanus <input type="checkbox"/> DTP</p> <p>Pertussis <input type="checkbox"/> _____/_____/_____, _____/_____/_____, _____/_____/_____</p> <p>Measles <input type="checkbox"/></p> <p>Mumps <input type="checkbox"/> MMR _____/_____/_____, _____/_____/_____</p> <p>Rubella <input type="checkbox"/></p> <p>HIB Meningitis (Haemophilus B) _____/_____/_____, _____/_____/_____, _____/_____/_____</p> <p>Hepatitis B _____/_____/_____, _____/_____/_____, _____/_____/_____</p> <p>Tuberculin Test (must be PPD Mantoux) _____/_____/_____ mm</p>																												
<p>Significant illnesses & injuries</p> <table border="0"> <tr> <th colspan="2">Diseases</th> <th colspan="2">Allergies</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hay Fever</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Measles (reg.)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Poison Oak, etc.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> German Measles</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Insect Stings</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Asthma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Others (specify)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Others (specify)</td> </tr> </table> <p>_____ _____ _____ _____</p>	Diseases		Allergies		Yes	No	Yes	No	<input type="checkbox"/>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> Hay Fever	<input type="checkbox"/>	<input type="checkbox"/> Measles (reg.)	<input type="checkbox"/>	<input type="checkbox"/> Poison Oak, etc.	<input type="checkbox"/>	<input type="checkbox"/> German Measles	<input type="checkbox"/>	<input type="checkbox"/> Insect Stings	<input type="checkbox"/>	<input type="checkbox"/> Mumps	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Others (specify)	<input type="checkbox"/>	<input type="checkbox"/> Others (specify)	
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Authorization To Treat A Minor

I (we) the undersigned parents or legal guardians of the minor named above do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act of a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the parent or guardian listed above as "parent" prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the person cannot be reached.

Signature of parent or guardian _____ Date: _____

St. Michael's Prep admits students of any race, color, religion or ethnic origin to all the rights, privileges, programs and activities of the school