MODEL SECONDARY SCHOOL FOR THE DEAF

PART A – SECTION 1

Answer all questions in Part A. Your private physician should complete Part B. The information in this form is confidential and is used only by the attending medical staff. No information will be released without your permission. All parts of this form must be completed appropriately. When completed it should be returned to: Student Health Services; Gallaudet University; 800 Florida Avenue, NE; Washington, DC 2002-3695

NO HEALTH CARE WILL BE GIVEN, other than for emergencies determined by the medical staff, until the completed medical/physical forms are on file in the Student Health Service. It is necessary to enforce this policy for the protection of our students, medical staff, and the school. Treatment without proper knowledge of existing medical allergies and/or conditions is hazardous to the patient. There also must be parental permission to treat minors (people under the age of 18 years).

It is advised that ALL students carry, at ALL times, their school identification cards, and the name, address, and policy number of their medical insurance.

Student's Printed Name _____ Date of Birth _____ Gender: ☐ M ☐ F

Place of Birth _____ Religion _____

Parent/Guardian's Printed Name _____ ( ) Home Phone _____ ( ) Work Phone _____

Home Address _____ City/State/Zip _____

IF UNABLE TO CONTACT PARENT/GUARDIAN, WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY?

Person's Printed Name _____ ( ) Home Phone _____ ( ) Work Phone _____

Relationship _____ Home Address _____ City/State/Zip _____

HEALTH INSURANCE COVERAGE: MSSD requires all students to have their own health insurance coverage. Families with private insurance must contact providers and advise them that their child will need out-of-areas services. This will ensure faster and more effective services should the student have an injury and require immediate service.

☐ Copy of Health Insurance Card (both sides) is attached to the form.

AUTHORIZATION FOR MEDICAL TREATMENT: To all MSSD Parents/Guardians and Students: I authorize the Model Secondary School for the Deaf, through its agents and employees, to furnish such diagnostic and therapeutic procedures, voluntary immunizations, operative procedures, and transportation as may be deemed necessary by its medical staff on my child's behalf. It is understood that with this authorization any medical or medically related services will be provided for my child by any health care provider or hospital in the event of sudden illness, accident, or any other emergency.

This authorization does not include the right to authorize any surgical procedures of a non-emergency nature for my child. I assume the full responsibility for all medical, hospital, lab, and referral expenses in and above insurance reimbursement thus incurred on behalf of my child. I agree to supply the Model Secondary School the names and addresses of my child's doctor(s) and any information regarding special health problems and medications throughout the school year. I agree to supply the Student Health Service with information updating any changes in my child's medical condition and a plan of care for those changes, by providing a written statement for this purpose from my child's health care provider. I am responsible for ensuring that all prescription and non-prescription medications are brought to the Student Health Service to be administered to my child in keeping with the policy followed by the Model Secondary School for the Deaf. I hereby represent that I have read the foregoing "Authorization for Medical Treatment," and that I understand and agree with all of its terms, and that I have the authority to execute the said Authorization in connection with any medical and medically related services that may be provided to my child/ward.

Parent/Guardian's Signature (Student's Signature if over 18) _____ Date _____

RECORD RELEASE AUTHORIZATION: I hereby give my permission for the Student Health Service to release any and all medical information to representatives of Gallaudet/MSSD who may have a legitimate need for such information in order to accomplish their professional responsibilities.

Parent/Guardian's Signature or Student's Signature if over 18 _____ Date _____

PART A – SECTION 2

Name: _____

FAMILY HISTORY – Please follow the instructions given for each heading outlined below.

FAMILY: Print the names of your relatives, *living or dead*, in the list below.	**DEAF: Answer YES, NO or H.H. for hard of hear-ing.**	OCCUPATION: Give occupation for all listed at left.	YEAR OF BIRTH/ HEALTH STATUS: Give the year of birth for all relatives listed at the left and mark an (X) to individuals whether their health is good or poor.			ILLNESS: Place an (X) in the appropriate column for any illness that the relatives listed at the left have now or have had.																		DEATHS: If a relative you have listed has died, write the cause of death and the age of death in the columns below	
			Year of Birth	Good	Poor	Allergies or Asthma	Anemia	Bleeding Tendencies	Cancer or Tumor	Cholesterol Problems	Diabetes	Epilepsy	Glaucoma	Other Visual Problems	Heart Trouble	High Blood Pressure	Kidney or Bladder Trouble	Migraine Headache	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Ducosnal Ulcer	Stroke	Tuberculosis	Cause of Death	Age
Father:																									
Mother:																									
Brothers or Sisters:																									
Spouse:																									
Children:																									
Grandparents:																									

PART A – SECTION 3

Name: _____

PAST HISTORY – Please indicate problems you have now or may have had in the past. Explain all "yes" answers. Use an extra sheet of paper if necessary. If you have a serious medical problem for which you see a physician regularly, please enclose a written report of history and treatment from that physician.

A. General Information — Please circle

	Yes	No
ADD/ADHD:		
Acne:	Yes	No
Alcohol Problem:	Yes	No
Allergies:	Yes	No
Anemia:	Yes	No
Asthma:	Yes	No
Back Problems:	Yes	No
Blackouts (fainting):	Yes	No
Bladder Infection (cystitis):	Yes	No
Bleeding Trait/Sickle Cell:	Yes	No
Bronchitis – Chronic:	Yes	No
Cancer (location): _____	Yes	No
Cerebral Palsy:	Yes	No
Chlamydia:	Yes	No
Chicken Pox:	Yes	No
Colitis:	Yes	No
Condyloma (genital warts):	Yes	No
Deafness:	Yes	No
Age of onset: _____ Cause: _____		
Depression:	Yes	No
Diabetes:	Yes	No
Dizziness:	Yes	No
Drug Dependency (specify: _____	Yes	No
Dyslexia:	Yes	No
Ear infections:	Yes	No
Eating Disorders (anorexia, bullmia):	Yes	No
Eczema:	Yes	No
Emotional or Mental Illness:	Yes	No
Epilepsy or Seizures:	Yes	No
Eye Problem (specify): _____	Yes	No
Fibrocystic Breast Disease:	Yes	No
Gallbladder Problems:	Yes	No
Gonorrhea:	Yes	No
Hard of Hearing:	Yes	No
Age of onset: _____ Cause: _____		
Hay Fever:	Yes	No
Headaches (migraine or tension):	Yes	No
Heart Problem		
Palpitations:	Yes	No
Rheumatic Heart Disease:	Yes	No
Heart Murmur:	Yes	No
Enlarged Heart:	Yes	No
Other: _____	Yes	No
Hepatitis (type: _____)	Yes	No
Herpes (genital, zoster):	Yes	No
High Blood Pressure:	Yes	No
Hypoglycemia (low blood sugar):	Yes	No
Infectious Mononucleosis:	Yes	No
Kidney Infections or Disease:	Yes	No
Measles:	Yes	No
Meningitis/Encephalitis:	Yes	No
Mumps:	Yes	No
Nervous Stomach:	Yes	No
Obesity (greater than 20 lbs overweight:	Yes	No
Ovarian Cyst:	Yes	No
Pelvic Infection:	Yes	No
Phlebitis:	Yes	No
Pneumonia:	Yes	No
Rheumatic Fever:	Yes	No
Rheumatoid Arthritis:	Yes	No
Rubella (German measles):	Yes	No
Sinus Problem – Chronic:	Yes	No
Syphilis:	Yes	No
Thyroid Problem:	Yes	No
Tuberculosis:	Yes	No
Ulcer (gastric or duodenal):	Yes	No
Vagintis (recurrent):	Yes	No
Other problems not listed:	Yes	No

Specify: _____

_____

_____

_____

Have you ever been advised to have surgery that was not done? Yes No

If yes, specify: _____

_____

B. Emotional — Please circle

	Yes	No
Do you usually feel sad, lonely, or depressed?	Yes	No
Do you often cry?	Yes	No
Are you nervous around strangers?	Yes	No
Is it hard for you to make decisions?	Yes	No
Is it hard for you to remember or concentrate?	Yes	No
Do you have problems relaxing?	Yes	No
Do you worry about things generally?	Yes	No
Do you often have frightening thoughts/dreams?	Yes	No
Are you easily upset by criticism?	Yes	No
Do you tend to be shy or sensitive?	Yes	No
Do you lose your temper often?	Yes	No
Do small things often annoy you?	Yes	No
Are you disturbed by any family problems?	Yes	No
Are you having any sexual difficulties?	Yes	No
Do you get "uptight" before exams?	Yes	No
Do you feel this affects your grades?	Yes	No
Have you ever wished you could kill yourself?	Yes	No
Have you ever desired or sought psychiatric help?	Yes	No
Are you exhausted or fatigued most of the time?	Yes	No
Do you have any problems sleeping?	Yes	No
Do you feel positive about the future?	Yes	No

C. MEN ONLY — Please circle

(if you consider a question too personal, you may omit it)

	Yes	No
Have you eve had …		
An enlarged or infected prostate?	Yes	No
Any burning, pus, discharge from your penis?	Yes	No
Any swelling or lumps in your testicles?	Yes	No
Treatment for genital herpes?	Yes	No

D. WOMEN ONLY — Please circle

(if you consider a question too personal, you may omit it)

Menstrual History:

Age of onset: _____ Regular cycles? Yes No

Cycle every: _____ days from start to start.

PART A – SECTION 3 (continued)

Name: _____

D. WOMEN ONLY (Continued from previous page)

Usual duration: _____ days.
Flow: ❒ Heavy ❒ Medium ❒ Light
Pain or cramps? ..... Yes No
Pregnancies? ..... Yes No
Method of birth control (if applicable):
Date of last PAP Smear: _____
Have you ever been treated for genital herpes? ..... Yes No
Did your mother use the medication Diethyistibestrol (DES) during her pregnancy? ..... Yes No

E. ALLERGIES

An allergy is a skin rash, hives, difficulty breathing, joint pain/swelling, or fever after exposure to a sensitizing agent.

Do you have any allergies? ..... Yes No
If so, what? (example: drugs, food, stings, bites, injections, pollen)

F. DRUGS AND MEDICATIONS — Please circle

D = Daily FQ = Frequently OC = Occasionally N = Never

Do you use:	D	FQ	OC	N
DRUGS				
Alcohol:	❒	❒	❒	❒
Cigarettes (nicotine):	❒	❒	❒	❒
Cocaine/Crack/Heroin:	❒	❒	❒	❒
Coffee/Soft Drinks (caffeine):	❒	❒	❒	❒
LSD/PCP:	❒	❒	❒	❒
Marijuana/Pot/Hashish/THC:	❒	❒	❒	❒
Tobacco (chewing):	❒	❒	❒	❒
Speed/Downers/Quaaludes:	❒	❒	❒	❒
MEDICINES – specify				
Asthma Medicine:	❒	❒	❒	❒
Antibiotics:	❒	❒	❒	❒
Antihistamines:	❒	❒	❒	❒
Blood pressure Medicine:	❒	❒	❒	❒
Birth Control Pills:	❒	❒	❒	❒
Decongestants:	❒	❒	❒	❒
Diuretics (Fluid Pills):	❒	❒	❒	❒
Diabetes Medicine:	❒	❒	❒	❒
Diet Pills/Amphetamines:	❒	❒	❒	❒
Epilepsy/Seizure Medicine:	❒	❒	❒	❒
Laxatives:	❒	❒	❒	❒
Sedatives/Tranquilizers/Barbiturates:	❒	❒	❒	❒
Thyroid Medicine:	❒	❒	❒	❒
Vitamins (Specify):	❒	❒	❒	❒
OTHER				
Aspirin:	❒	❒	❒	❒
Cortisone:	❒	❒	❒	❒
Codeine:	❒	❒	❒	❒
Deluded:	❒	❒	❒	❒
Ibuprofen:	❒	❒	❒	❒
Tylenol:	❒	❒	❒	❒
Other:	❒	❒	❒	❒

G. INJURIES — Please circle

Broken Bones: ..... Yes No
Dislocations: ..... Yes No
Concussions, head injuries: ..... Yes No
Been knocked unconscious: ..... Yes No
Other injuries: ..... Yes No

If "yes", explain, including dates: _____

H. SURGERY — Please circle

Have you had surgery for:
Tonsils/Adenoids: ..... Yes No
Appendix: ..... Yes No
Hernia: ..... Yes No
Other operations: ..... Yes No

If "yes", explain, including dates: _____

I. VISION — Please circle

How is your balance? ❒ Good ❒ Fair ❒ Poor
Do you have trouble walking or staying upright in the dark? ..... Yes No

How is your eyesight? ❒ Good ❒ Fair ❒ Poor
Do you wear glasses or contact lenses? ..... Yes No
If "yes," attach a copy of your prescription.

J. EXERCISE

Describe types, times per week, and amount of time:

K. NUTRITION

Describe briefly your diet on an average day, including any restrictions:

L. OTHERS

Do you have any problems not covered by this questionnaire? If "yes," explain:

PART B – For the Health Care Provider

Name: _____ Date of Birth: _____

IMMUNIZATIONS – Immunizations must be verified by your health care provider. You must have: 1) Tetanus/diphtheria booster within the past 10 years; 2) Salk polio vaccine within the past 5 years or a complete oral polio vaccine (TOPV) series; 3) Two MMR (measles, mumps, rubella) vaccines or evidence of immunity to disease by titre; 4) Varicella vaccine or evidence of disease; 5) Hepatitis B vaccine or evidence of immunity by titre.

	IMMUNIZATION HISTORY				
Tetanus/Diphtheria					
TD/TDAP					
OPV (Polio Vaccine (Type: _____)					
IPV					
MMR (Measles, Mumps, Rubella)					
Varicella (or at what age child had chicken pox: _____)					
Hepatitis A					
Hepatitis B (Type:					
Meningococcal Vaccine					
HPV (Human Papillomavirus)					

PHYSICAL EXAMINATION – All new students must have a physical exam and tuberculin skin test, within 12 months prior to admission to the Model Secondary School for the Deaf, and the results must arrive with the complete Medical History Form.

	Date	Result	Date	Result	Date	Result
Tuberculin (Mantoux) PPD-5 TU						
Chest X-Ray (if PPD positive)						
Urine						
Other						

GENERAL APPEARANCE

HT: _____ WT: _____ BP: _____ PULSE: _____ Respiration R: _____

VISUAL ACUITY

OD: _____ OS: _____ Combined: _____ w/correction OD: _____ w/correction OS: _____ Combined: _____

Head: _____ Neck: _____ Musculoskeletal: _____

Eyes, including funduscopic: _____ Chest: _____ Skin: _____

Ears: _____ Lungs: _____ Extremities: _____

Hearing aid-make and type, if applicable: Heart: _____ Lymphatics: _____

_____ Breast: _____ Neurological: _____

Nose and Mouth: _____ Abdomen: _____ Developmental: _____

Teeth and Gums: _____ Hernias: _____ Impression: _____

Pharynx: _____ Rectal: _____ Impression: _____

Tonsils: _____ GU: _____ Positive Findings: _____

Thyroid: _____ Genitalia: _____ _____

IMPORTANT FOR SPORTS PARTICIPANTS:

This test must be conducted if student wishes to participate in sports. If not conducted, student will not be able to participate in any sports.

Exercise test: Jumping jacks for 1-2 minutes.

	BLOOD PRESSURE	HR	RHYTHM	MURMURS
Resting				
At Peak Exercise				
After 5 Minute Rest				

CLEARANCE FOR SPORTS PARTICIPATION:

☐ Cleared ☐ Cleared after complete evaluation for: _____

☐ Not cleared for: ☐ Collision ☐ Contact ☐ Non-contact: strenuous, moderate strenuous

_____ _____ _____

Examining Physician's Signature Printed Name Date of Examination

_____ _____

Address Phone