

Health History

*To be completed by primary care provider within one year of coming to the Mountain School– confidential.
Please answer all questions, do not leave any section blank. If not applicable or none, please indicate that.*

Student Name _____ Date of Birth _____

Height _____ Weight _____ BP _____ Vision _____

Date of Physical _____ (must be within one year of arrival on campus)

(A copy of provider office form is acceptable, as long as it includes ALL of the information requested.)

Medical History (include temporary or chronic medical problems or mental health issues, injuries, eating problems/disorders...)
If you have questions or concerns, please call and discuss with our Head Advisor or Director.

If the student has asthma, describe triggers and treatment/medication used:

Allergies: (include medicine, food, environmental and please also list the symptoms of the allergy ie: hives, headache...)

Medications: (prescribed and over-the-counter, daily and occasional use)
See back of sheet for consent and prescriber order forms.

Immunization History (MUST be submitted prior to student’s arrival on campus)

Required: (provide dates vaccines administered)

DPT/Td/DT: #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Td: _____ (must be within last 10 years)

MMR: #1 _____ #2 _____ (2 doses required)

Polio: #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Hep B: #1 _____ #2 _____ #3 _____

Meningococcal: _____

For health records / not required: (provide dates vaccines administered)

Tuberculin test: Type _____ Date _____ Result _____

Hib: #1 _____ #2 _____ #3 _____ #4 _____

Varicella (chicken pox): date of disease or vaccine _____

Hepatitis A #1 _____ #2 _____

Primary Care Provider Signature _____ Date _____

Name _____

Address _____

Phone _____

Medication Order

(to be completed by the licensed prescriber - confidential)

Date _____

Student Name _____ Date of Birth _____

Prescriber Name (print) _____

Prescriber Phone _____

For each prescription medication, include medication name, route of administration, frequency and/or time of administration, and any instructions specific to this student regarding medication side effects, contraindications, etc.

1. _____

2. _____

3. _____

4. _____

Prescriber signature: _____

I give permission for this student to self-administer the above medications if the school health officer determines that it is safe and appropriate.

Circle Yes No Prescriber signature: _____