

NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____ AGE: _____ SEX: M F
DATE OF BIRTH (M/D/Y): ____/____/____ HOME PHONE: (____) _____ - _____ GRADE: _____
HOME ADDRESS: _____
STREET ADDRESS CITY STATE ZIP
MOTHER'S NAME: _____ MOTHER'S SOCIAL SECURITY #: _____ - _____ - _____
MOTHER'S ADDRESS: _____
STREET ADDRESS CITY STATE ZIP
MOTHER'S WORK PHONE: (____) _____ - _____ FATHER'S WORK PHONE: (____) _____ - _____
FATHER'S NAME: _____ FATHER'S SOCIETY SECURITY #: _____ - _____ - _____
FATHER'S ADDRESS: _____
STREET ADDRESS CITY STATE ZIP
LEGAL GUARDIAN'S NAME: _____ LEGAL GUARDIAN'S SOCIAL SECURITY #: _____ - _____ - _____
LEGAL GUARDIAN'S ADDRESS: _____
STREET ADDRESS CITY STATE ZIP
LEGAL GUARDIAN'S WORK PHONE: (____) _____ - _____
IN CASE OF AN EMERGENCY CONTACT: _____ RELATIONSHIP: (I.E. FRIEND/RELATIVE, ETC.) _____
EMERGENCY CONTACT WORK PHONE: (____) _____ - _____ HOME PHONE: (____) _____ - _____

IMMUNIZATION RECORDS

1. Records need to be authorized by a physician or a photocopy of school health records is acceptable.
2. State law requires all students to be fully immunized before attending school.
3. No student will be admitted to Washington Academy without adequate immunizations being proven.
4. Proper immunizations includes: 4 doses of D PT MMR: 2 doses. Oral Polio: 4 doses
5. NO STUDENT CAN BEGIN CLASSES WITHOUT PROPER IMMUNIZATION DOCUMENTATION.

DPT series (m/d/y): 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____ 4th ____/____/____
OPV/IPV (m/d/y): 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____ 4th ____/____/____
Hepatitis B (HBV) (m/d/y): 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____
MMR1 (m/d/y): ____/____/____ MMR2 (m/d/y): ____/____/____
TB test or Chest x-ray in the past year: ____/____/____ DT – date of last shot (due every ten years): ____/____/____
Varicella Immunization : ____/____/____ If not immunized, date of Disease: ____/____/____
Varicella Disease is verified by your signature and is required by United States Law

By signing this form you are verifying that this student is in good physical health and can participate in sports.

PHYSICIAN'S NAME (PLEASE PRINT) _____ PHYSICIAN'S SIGNATURE _____ DATE _____
STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHYSICAL HEALTH

Medical/Surgical History: _____
Allergies: Yes No If yes, please specify: _____
Medications: Yes No If yes, please specify: _____
Please list any health problems you have or may have had in the past: _____

MENTAL HEALTH

Is your child currently receiving or have received in the past, counseling services? Yes No

If so, when and with whom?

____/____/____ _____
DATE (M/D/Y) NAME ADDRESS

Is this a service you wish to continue? Yes No

Is your child now or in the past taking medication related to mental health needs? Yes No

If yes, what is the name of the medication? _____ Dosage? _____

How long has your child been taking this medication? _____

Has your child ever experienced depression or attempted suicide? Yes No

If yes, when? _____ How was the situation handled? _____

DENTAL HEALTH

All necessary dental work must be done prior to coming to school. A clean bill of dental health must accompany the health records.

DENTIST'S NAME (____)____-____
DENTIST TELEPHONE

DENTIST'S ADDRESS CITY STATE ZIP

INSURANCE INFORMATION

Please send a copy (front and back) of your current insurance card.

PRIMARY INSURANCE: _____ Is this an HMO? Yes No
COMPANY NAME

(____)____-____
COMPANY TELEPHONE COMPANY STREET ADDRESS CITY STATE ZIP

SUBSCRIBER GROUP # I.D. #

EMPLOYER EMPLOYER'S STREET ADDRESS CITY STATE ZIP

SECONDARY INSURANCE: _____
COMPANY NAME

COMPANY STREET ADDRESS CITY STATE ZIP

SUBSCRIBER GROUP # I.D. #

FAMILY PHYSICIAN'S NAME (____)____-____
FAMILY PHYSICIAN'S TELEPHONE

FAMILY PHYSICIAN'S ADDRESS CITY STATE ZIP

PARENT PERMISSION DECLARATION

- I authorize designated school personnel to act as my child's guardian for the entire school year.
 - I give consent for my child to participate in and be treated for any injuries in the event of an emergency.
 - I authorize the use of anesthesia and blood products if necessary in the event of an emergency, operation, or treatment in an accredited hospital.
 - I authorize trained school personnel to administer medications to my child as needed.
 - I give consent for the administration of necessary immunizations required by Maine State law that my child has not received prior to enrollment. I understand I will be charged accordingly by the school physician.
- These consents and declarations will discontinue upon my child's withdrawal.
- _____
SIGNATURE OF PARENT/ GUARDIAN DATE