



# Houghton Academy

9790 Thayer Street, Houghton, NY 14744  
Phone: (585) 567-8115; Fax: (585) 567-8048  
E-Mail: [Admissions@HoughtonAcademy.org](mailto:Admissions@HoughtonAcademy.org)  
Website: [www.houghtonacademy.org](http://www.houghtonacademy.org)

## MEDICAL INFORMATION FORM Please print or type.

Male  Female

\_\_\_\_\_  
First Name Middle Name Family Name Date of Birth (Mo/Day/Year)

\_\_\_\_\_  
Home Address Home Address (continued)

\_\_\_\_\_  
City State/Province Country Zip/Postal Code

\_\_\_\_\_  
Social Security Number (if any)

### In Case of Emergency

- 1) I give authorization for Houghton Academy staff or host family parent (for boarding students) to make decisions regarding medical/surgical care in event of an emergency or acute illness when a parent or guardian is not immediately available for a quick and urgent decision.
- 2) I give authorization for the exchange of pertinent medical/surgical information between Houghton Academy staff, including the school nurse, the school physicians, and any other medical personnel involved in the care and treatment of the student.
- 3) I give authorization for Houghton Academy to obtain copies of medical records from a hospital, outpatient department or doctor's office when they are pertinent to the continuing care of the student and thus need to be in the school record.

This authorization covers any dates in which the student is enrolled at Houghton Academy. I hereby sign consent to all the provisions above:

\_\_\_\_\_  
Applicant If 18 years old or over Date

\_\_\_\_\_  
Parent/Guardian (signature required if applicant is under 18 years of age) Date

### Emergency Contact Information

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City State/Province Country Zip/Postal Code

\_\_\_\_\_  
Home Telephone (include ALL country, city, and area codes) Work Telephone (include ALL country, city, and area codes)

\_\_\_\_\_  
Parent's Fax Number (include ALL country, city, and area codes) Parent's E-Mail Address

\_\_\_\_\_  
Alternate Emergency Contact Person (someone Houghton Academy may contact if the parent cannot be reached)

\_\_\_\_\_  
Alternate Contact Person's Address

\_\_\_\_\_  
Alternate Daytime Emergency Phone Number (include ALL country, city, and area codes)

\_\_\_\_\_  
Fax Number (include ALL country, city, and area codes) E-Mail Address (must be English-speaking/reading contact person)



Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

*This page may be completed by a parent or a physician, but not the student.*

**Allergies and Sensitivities**

Is there a history of skin reaction or other reaction or sickness following injections or oral administration of any of the following?  
If yes, please note the **DATE** and **TREATMENT**

NO	YES(DATE)	ITEM	TREATMENT
		Penicillin or other antibiotics	
		Morphine, Codeine, Demerol, other narcotics	
		Aspirin, empirin or other pain remedies	
		Tetanus, antitoxin or other serums	
		Any foods, such as egg, milk, chocolate, or nuts	
		Pets/Animals (Please explain)	
		Novocaine or other anesthetics	
		Sulfa drugs	
		Adhesive tape or latex (circle which)	
		Iodine or merthiolate	
		Any other drug or medication	
		Any other allergies? If yes, please explain below.	

Additional Explanation of Allergies/Treatments:

**Medical History**

Has the student had any of these conditions, diseases or injuries? *If yes, give date(s).*

NO	YES(DATE)		NO	YES(DATE)	
		Measles			Spitting up blood
		Mumps			Chronic or frequent cough
		Chickenpox			Asthma
		Epilepsy			Spitting up blood
		Diabetes			Fainting
		Concussion or Head Injuries			Headaches
		Rheumatic Fever or Heart Disease			Nosebleeds
		Eating Disorder (anorexia/bulimia)			Chronic sinus trouble
		Hepatitis			Impaired hearing
		Malaria* *			Dizziness
		Strokes			Cancer
		Tuberculosis			Severe Acne
		Fractures or Broken bones Which bones? Dates:			Do you wear glasses/contacts? <i>(Please bring an extra pair of glasses or contacts with you.)</i>

**\*\*If the student has had malaria, he/she should bring malaria medicine to take for six (6) weeks.**

Please note the name of the malaria medication:

Please note the dosage:

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

**CLINICAL EVALUATION** (These 2 pages must be filled out by a physician in conjunction with a physical examination)

Normal	Check Each Item	Abnormal
	Head, Face, Neck, Scalp	
	Nose	
	Sinuses	
	Mouth and Throat	
	Ears, General (Int. and Ext.)	
	Drums (perforated)	
	Eyes	
	Ophthalmoscopic	
	Pupils	
	Ocular Motility	
	Lungs and Chest	
	Heart	
	Vascular System	
	Abdomen and Viscera	

Normal	Check Each Item	Abnormal
	Anus and Rectum	
	Endocrine System	
	G – U System	
	Upper Extremities	
	Feet	
	Lower Extremities	
	Spine, Other Musculoskeletal	
	Body Marks, Scars, Tattoos	
	Skin, Lymphatics	
	Neurologic	
	Psychiatric	
	Menstruation (Female Only)	

**MEASUREMENTS AND OTHER FINDINGS**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Build: slender medium heavy

**BLOOD PRESSURE**

Sitting: \_\_\_\_\_

**PULSE**

Sitting: \_\_\_\_\_

**SPORTS PARTICIPATION**

No Yes May this student participate *without restriction* in sports activities?

**GENERAL HEALTH QUESTIONS**

No Yes Any past surgeries or hospital stay? If yes, please explain.

No Yes Any past counseling or psychiatric services? If yes, please explain.

**MEDICATIONS**

No Yes Do you plan to bring any medications or herbs with you to Houghton Academy? *If yes, you must provide, in **English**, a listing with the **name** of the drug or herb, the **indication**, the **strength**, and **reason** for its use. All medications brought to the Nursing Office upon arrival.*

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

**IMMUNIZATION RECORD** (Asterisks denote minimum mandatory vaccine to comply with NYS regulations)

Vaccine	Date each dose was given				
	1 <sup>st</sup> Month/Day/Year	2 <sup>nd</sup> Month/Day/Year	3 <sup>rd</sup> Month/Day/Year	4 <sup>th</sup> Month/Day/Year	5 <sup>th</sup> Month/Day/Year
<b>DTP</b> (Diphtheria, Pertussis, Tetanus) (3 Doses are required)	*	*	*		
<b>TD Booster</b> (Tetanus) (must be within 10 years)					
<b>POLIO Vaccine</b> <b>IPV -4 doses are required</b> <b>-OR- OPV -3 doses are required</b>	IPV 1*	IPV 2*	IPV 3*	IPV 4*	IPV 5
<b>MMR</b> (Measles, Mumps, Rubella, combined) 2 Doses are required	*	*			
<b>OR</b>	**Measles (Rubeola: 10 day red measles) (2 doses of individual vaccine required)	*	*	If no immunization, give date student had Measles:	
	**Rubella (German Measles – 3 days) (1 dose of individual vaccine required)	*		If no immunization, give date student had Rubella:	
	**Mumps (1 dose of individual vaccine required)	*		If no immunization, give date student had Mumps:	
<b>Hepatitis B</b> (3 doses are required)	*	*	*		
<b>Varicella</b> (Vaccine, positive titer, or physician's documentation of disease for student entering grade 7)				If no immunization, give date student had Chickenpox:	
<b>Other Vaccines Received</b> (Please list vaccine(s) with dates)					

\*\*If the student has had measles, mumps, or rubella, and has not received a vaccine for it, a positive titer (blood test) to document immunity must be submitted. A paper from the doctor must be included.

**Tuberculosis Clearance (International Students Only)**

Skin Test: Date: \_\_\_\_\_

Positive or Negative: \_\_\_\_\_

If skin Test is POSITIVE, an X-Ray is required:

Chest X-Ray: Date \_\_\_\_\_

Positive or Negative: \_\_\_\_\_

If chest x-ray is positive, what treatment was given? \_\_\_\_\_

**Physician Information**

Physician's Signature or Stamp Required

Date

Physician's Name (Please print)

Physician's Address

Physician's Address (continued)

City

State/Province

Country

Zip/Postal Code

Physician's Phone (include ALL country, city, and area codes)

Physician's Fax Number (include ALL country, city, and area codes)

**ATTENTION, BOARDING STUDENTS:** Houghton Academy complies with New York State regulations governing immunization requirements: Any required immunizations not obtained prior to your arrival will be administered after you arrive, and any fees for obtaining them will be billed to the student's account.