



HEALTH FORM

THE BEMENT SCHOOL
94 OLD MAIN STREET
PO BOX 8
DEERFIELD, MA 01342
Phone: 413-475-3044
Fax: 413-774-7863
esl@bement.org

FOR STUDENTS APPLYING TO THE ELAC SUMMER PROGRAM

Completion of this form is required for admission into the summer program. Sections of this form will accompany your child on trips away from school. All information on the form is confidential. Providing complete and accurate information is greatly appreciated and may be very important to your child's health.

Identifying Information

Student's Name _____

Date of Birth _____ **Place of Birth** _____

Name of Father/ Mother _____

Home Address _____

Home phone number: _____ **Fax:** _____

e-mail: _____ **Cell phone:** _____

Work phone number: _____ **Fax:** _____

e-mail: _____

Alternate responsible person to be reached in case of an emergency if parent or guardian is unavailable.

Name _____

Address _____

Home phone number: _____ **Work phone number:** _____



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Permissions

Student's name _____

The following permissions are required to facilitate the timely provision of medical care while your child is at school. The signature of a parent or guardian is required on this form prior to participation in classes and sporting activities. Every effort will be made to contact parents or guardian for serious illnesses, serious injuries, operations or protracted or complex treatments.

1. I, hereby grant permission to The Bement School to provide medical care to my child during the time that she attends the summer program. I grant permission to the above-mentioned school to authorize and consent to any medical treatment of my child in the event of a medical or surgical emergency. This permission is in the event that I am unable to be contacted and medical or surgical judgment indicates that further delay would represent a risk to my child.
2. I, hereby acknowledge awareness that participation in all sports, activities and events involves some risk of injury, which may occur as a result of unavoidable accidents. I, hereby, accept these risks and give consent to participation by my child in all sports, activities and events while she is attending school.

Signature of Parent or Guardian

_____ Date _____

- If your child is covered by an existing United States based insurance policy, please include the following information:

Name of insurance company _____

Phone number _____ Policy number _____

Please include **photocopies** of the front and back of your insurance card.



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Medical Information

Student's Name: _____

Please use this space to provide a summary of medical information while your child is away from home.

Medical concerns:

Daily medications prescribed by a doctor. Give dosage and frequency.

Frequently taken medications. These include non-prescription drugs. Please describe frequency and dosage.

Allergies: Please specify allergies to drugs, food, plants, or animals.

Is your child allergic to bee stings? _____

Has this student ever experienced a life threatening allergic reaction? _____

If so, has this student been instructed in the use of self-administered epinephrine? _____

Date of last tetanus injection _____

Does the student wear glasses or contact lenses? _____



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Physician's Statement

After conducting a routine physical exam, please use the following space to summarize the student's medical problems list (including allergies) the abnormalities on physical exam and any medications that he/she may be taking (intermittently or chronically) Please note the nature and severity of any allergic reactions (ex, rash, hives, anaphylaxis, etc)

Physical Measurements

Student's Name: _____
Height _____ (inches) Weight _____ (pounds)
Blood pressure _____ Heart Rate _____
Vision _____

Medical Problem List:

Abnormalities on Physical Exam:

Medications:

Has this student ever experienced a life threatening allergic reaction? _____
If so, has this student been instructed in the use of self-administered epinephrine? _____

Signature of physician _____
Name _____
Phone number _____