HEALTH INFORMATION FORM

(OV Christian Academy and OV Childcare)

State law (Ref. Code of Virginia#22.1-270) requires that your child is completely immunized and receives a comprehensive physical examination before entering kindergarten. This form must be completed within one year before your child's first day of kindergarten or elementary school.

Student's Name: _____ Grade: _____
Last *First* *M.i.*

Date of Birth: _____/_____/_____ Sex _____ Social Security #: _____/____/_____ Height: _____ Weight: _____

Address: _____
Street address *City* *State* *Zip*

Assessment of Student's Health

To the best of your knowledge, has your child had any problem with any of the following:

CONDITION	YES	COMMENTS	CONDITION	YES	COMMENTS
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head Injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problems			Seizures		
Bleeding problem			Sickle Cell Disease		
Bowel problems			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child: _____

_____

List all prescription and over-the-counter medications your child takes regularly: _____

_____

Has student been prescribed an inhaler or epipen? _____

Primary Care Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Health Insurance Carrier: _____ Policy #:_____ Phone #: _____

Consent to Emergency Medical Care and Treatment

Parental consent is required before a hospital's emergency department can give medical treatment to a minor. Every effort will be made to contact parents, but a completed consent form will expedite treatment. (An OVCA staff member will accompany your child to the hospital until an emergency contact person arrives.)

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to my child by a licensed physician or hospital in the event I am not available to consult with the attending physician, attempts to contact me have been unsuccessful, and the attending physician deems it advisable to proceed with such treatment(s).

Signature of Parent or Guardian: _____ Date _____

Printed Name of Parent or Guardian: _____

#1 EMERGENCY CONTACT (local person other than parent or guardian)

_____/_____/_____
Name Relationship Home Phone Work Phone Cell Phone

#2 EMERGENCY CONTACT (local person other than parent or guardian)

_____/_____/_____
Name Relationship Home Phone Work Phone Cell Phone

Immunizations

Copy of Immunization Record MUST be presented with enrollment paperwork in order for registration to be considered complete .

Minimum requirements for immunizations for entry into school (requirements are subject to change)

- 4 DTP – at least one dose of DTP after 4th birthday unless received 6 doses before 4th birthday,
- 3 Polio Vaccine – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday.
- Hib – 2-3 doses in infancy; 1 booster between 12–15 months; 11 dose between 15-60 months if unvaccinated.
- 3 Hep B doses – required for children born on or after January 1, 1994 and for students enrolling in 6th grade on or after July 1, 2001 if unvaccinated.
- 2 Measles – 1st dose on/after 12 months (365 days) of age; 2nd dose prior to entering kindergarten.
- 1 Mumps – on/after 12 months (365 days) of age.
- 1 Rubella – on/after 12 months (365 days) of age.
- 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months (365 days) of age.

Medical Exemption: As specified in the Code of Virginia # 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

DTP/DTaP (____) DT/Td (____) OPV/IPV (____) Pneum (____) Measles (____) Rubella (____) Mumps (____) HBV (____) Varicella (____)
This contraindication is permanent: (_____), or temporary (_____) and expected to preclude immunizations until _____/_____/_____

Signature of Medical Provider or Health Department Official: _____Date: _____/_____/_____

Religious Exemption: the Code of Virginia allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. Code of Virginia # 22.1-271.2, C (i).

I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment).

Next immunization due on: _____.

Signature of Medical Provider or Health Department Official: _____Date: _____/_____/_____

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATION AT SCHOOL

(please see Principal for separate authorization for prescribed medication)

Student's Name: _____
Last First MI

Grade: _____ Date of Birth: _____/_____/_____

Allergies: _____

Parent/Guardian Consent:

I am the parent/guardian of _____. I give my permission for him/her to take the below checked "over the counter medications." I hereby acknowledge that I have read and understood the regulations to the taking of medications as per the Ocean View Christian Academy Handbook, under Medication/Student Illness or Injury. I hereby release Ocean View Christian Academy and its employees from any claims or liability, connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

Medication I authorize my child to take on a "As Needed Basis" are: (please circle all that apply)

Tylenol Ibuprofen Sudafed Dimetapp Robitussin Tums Benadryl Cough Drops

I understand that this medication is kept in the academy office, and is only to be administered when the office staff feels that the child would benefit from these medications. If a medication is needed for my child that is not listed, it is my responsibility to bring that medication to the office, with the child's name on it, along with a completed medication form with proper dosage and administration times properly filled out.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date