School Clinic Records Medical Form *(to be completed by parents)*

APPLICANT INFORMATION

NAME (as appears in passport)

Last	First	Middle

Preferred Name	Date of Birth (mm/dd/yyyy)	Citizenship	Gender

Home Address	Home Telephone

PARENT/GUARDIAN INFORMATION

☐ **Father** ☐ Stepfather ☐ Legal Guardian 1		☐ **Mother** ☐ Stepmother ☐ Legal Guardian 2	
Last Name:		Last Name:	
First Name:		First Name:	
Middle Name:		Middle Name:	
Office Phone Number:		Office Phone Number:	
Mobile Number:		Mobile Number:	
Email Address:		Email Address:	
Emergency Contact Person (aside from above)		**Emergency Contact Person (aside from above)**	
Name:		Name:	
Mobile Number:		Mobile Number:	

Who is the custodial parent / guardian?	☐ Father / Guardian 1	☐ Mother / Guardian 2	☐ Both
To whom should correspondence with school clinic be sent?	☐ Father / Guardian 1	☐ Mother / Guardian 2	☐ Both

PAST HISTORY *(Please check if the child has a past history of the following diseases, please provide the date and age)*

Illness	*Date*	*Age*	*Illness*	*Date*	*Age*
☐ Asthma			☐ Measles		
☐ Chicken Pox			☐ Meningitis		
☐ Chronic Ear Infections or Otitis Media			☐ Mumps		
☐ Diabetes Type 1 ☐ / Type 2 ☐			☐ Primary Complex / TB		
☐ Epilepsy / Fainting Spells			☐ Rubella		
☐ Febrile Convulsions			☐ Scoliosis		
☐ Heart Disorder			☐ Skin Problems		
☐ Hepatis A / Hepatitis B			☐ Urinary Tract Infections		
☐ Covid-19			☐ Whooping Cough		
☐ Migraine			☐ Others		
Medications/ Supplements taken on a regular basis:					

Please indicate if the child has any allergies.

☐Food ________________________ ☐Medicine ________________________ ☐Others ________________________

AUTHORIZATION

I give consent for my child to receive the following:

First aid treatment at the school clinic ☐ YES ☐ NO   Non-prescription medicine in case of emergency ☐ YES ☐ NO

I acknowledge that it is my responsibility to inform the Beacon Academy clinic of any update in my child's medical records.

Parent's/ Guardian's Name and Signature ____ Date ____________________