



GADZOOSDAA STUDENT RESIDENCE APPLICATION

Application Year

2020-21

Medical Form 5

Student Last Name

First Name

Middle Name

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Birthdate

Student Cell Phone

Home Community

IN CASE OF EMERGENCY PLEASE NOTIFY:

First Name, Last Name

Relationship to Student

Daytime Phone

Night Phone

Home Address

Doctor's Name

Doctor's Phone

MEDICAL HISTORY

It is important that a student's medical history be as complete and accurate as possible. Previous and current medical problems, including all previous surgery as well as any significant injuries should be checked off.

- | | | | | |
|-----------------------------------------|--------------------------------------------|----------------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> SkinDisease | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> DislocatedJoint | <input type="checkbox"/> MetalScrew |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HeartProblem | <input type="checkbox"/> VisionImpairment | <input type="checkbox"/> Concussion | <input type="text"/> |
| <input type="checkbox"/> InfectiousMono | <input type="checkbox"/> NeckInjuryProblem | <input type="checkbox"/> EyeGlasses/Contacts | <input type="checkbox"/> ThyroidProblem | <input type="checkbox"/> Brace Required |
| <input type="checkbox"/> BackInjury | <input type="checkbox"/> KidneyDisease | <input type="checkbox"/> Asthma | <input type="checkbox"/> ShoulderInjury | <input type="text"/> |
| <input type="checkbox"/> Tendinitis | <input type="checkbox"/> Sprain | <input type="checkbox"/> KneeInjury | <input type="checkbox"/> Cast | |

Other Health

use other side if needed

ALLERGIES

MedicationAllergies

Food Allergies

Other Allergies

CURRENT PRESCRIPTIONS

Prescription

Prescription Dosage

Prescription Frequency

EMERGENCY MEDICAL CARE / OVER THE COUNTER MEDICATIONS

Please intial in boxes if you agree.

In case of an emergency, I give Gadzoosdaa Staff permission to bring my student to the hospital and obtain all medical and surgical help necessary.

I agree to allow Gadzoosdaa Staff to give my student over the counter remedies for colds, flu and pain management.

Custodial Parent/Legal Guardian Name

Custodial Parent/Legal Guardian Signature

Date