Discovery ChalleNGe Academy - Report of Medical History and Insurance Information

1. Student Name: _____ SSN: _____Birth Date _____Height _____Weight_____
2. Parent/ Guardian Name: _____ Parent/ Guardian Contact Number: _____
3. Statement of Health- Good☐ Fair☐ Poor☐ Explain:_____
4. Have you ever been hospitalized? Yes☐ No☐ For What? _____When? _____
5. Do you normally go to the Doctor for headaches, colds, or minor ailments? Yes ☐ No☐
6. Current Medications_____ Reason_____
7. Allergies **(List should include insect bites and stings, common foods, and medications)**_____
8. Your Doctor's Name_____Phone#_____24 hr. #_____
9. Do you wear braces? Yes☐ No☐ Do you wear contact lenses? Yes☐ No☐
10. Have you been hospitalized in the last 6 months? _____ For What? _____
11. Have you had a broken bone in the last 6 months? _____ What happened? _____
12. Are you under a Doctor's care for **ANY** condition, or diagnosis or prescribed medication? _____

NOTE: If you answered "Yes" to question 9, 10, or 11, you must include a "Doctor's Release" stating that you are emotionally and physically capable to participate in all components of the program. A physical exam and release is required for accepted students.

CIRCLE ALL OF THE ITEMS THAT APPLY NOW OR THAT YOU HAVE EVER EXPERIENCED. IF YOU CIRCLE ANY ITEM, PUT THE YEAR THAT THE CONDITION OCCURRED NEXT TO THE CONDITION, AND A BRIEF EXPLANATION BELOW IT.
If this is a current condition, write CURRENT next to the condition. Failure to disclose known issues could result in expulsion of student.

Eye, ear, nose, or throat trouble	Frequent indigestion	Pregnant at this time	Paralysis (include infantile)
Chronic or frequent colds/coughs	Stomach, liver, or intestinal	Treated for female disorder	Epilepsy, seizures, or fits
Severe tooth or gum trouble	Gall bladder trouble	Change in menstrual cycle	Motion sickness
Bleeds easily	Arthritis, rheumatism	Recent gain/loss of weight	Frequent trouble sleeping
Liver disorder/disease	Diabetes or Hypoglycemia	Had 1 or more children	Eating Disorder
Nose bleeds	Jaundice or hepatitis	Unconsciousness/Head Injury	Depression or heavy weeping
Skin disorders	Bone, joint or deformity	Thyroid trouble or goiter	Loss of memory or amnesia
Sinusitis, hay fever	Tumor, growth, cyst, cancer	Lameness or neuritis	Nervous disorder
Asthma, shortness of breath	Rupture/hernia	Broken Bones	Adverse reaction to medication
Coughed up blood	Anemia	Sickle Cell	Rectal disorder
Tuberculosis	Painful/frequent urination	recurrent back pain	Head Lice
Sleepwalker	Scarlet/ Rheumatic fever	Bedwetting since age 12	Swollen or painful joints
Dizziness or fainting spells	Palpitation or pounding heart	Leg or feet cramps	Kidney stone/ blood in urine
Frequent or severe headaches	Heart trouble or murmur	Sugar or albumin in urine	Loss of finger, toe, arm, or leg
High or low Blood Pressure	Sexually Transmitted Disease	Knee brace or back support	Painful or "trick" knee, shoulder, elbow
Attempted suicide			

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER (Must be MD, DO, PA, NP) _____

SIGNATURE OF PHYSICIAN OR EXAMINER _____ **DATE** _____

I, _____parent/guardian of _____ hereby agree to:
(Printed Name of Parent) (Printed Name of Student)

1. **Maintain active health insurance for the entire duration of the academy.**
2. **Ensure that all required vaccinations are up to date, in accordance to the academy's specifications, prior to the Academy's start date.**
3. **Provide $40 on intake day to cover any miscellaneous medical expenses.**

➔**Signature of Parent/Guardian** _____ **Signature of Parent/Guardian**_____

➔ **Applicant Signature**_____

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NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF EXAMINEE (Student) (Last, first, middle)	2. IDENTIFICATION NUMBER (SS#)	3. DOB	DATE OF EXAM:

4a. HOME STREET ADDRESS(Street, City, State, ZIP)			5. EXAMINING FACILITY (STAMP HERE)
4b. CITY	4c. STATE	4d. ZIP CODE	

6. PURPOSE OF EXAMINATION

SPORTS PHYSICAL FOR APPLICATION TO ATTEND DISCOVERY CHALLENGE ACADEMY AND IMMUNIZATION UPDATE REQUIRED.

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED(Use additional pages if necessary)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.	ROUTE
c. ALLERGIES(Include insect bites/stings and common foods)			
	d. HEIGHT	e. WEIGHT	

8. PATIENT'S OCCUPATION

STUDENT

9. ARE YOU (check one)

☐ RIGHT HANDED ☐ LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM. IF "YES' EXPLAIN IN BLANK SPACE ON 2ND PAGE. LIST EXPLANATION BY ITEM NUMBER

CHECK EACH ITEM	YES	NO	YEAR	CHECK EACH ITEM	YES	NO	YEAR	CHECK EACH ITEM	YES	NO	YEAR
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
Tuberculosis or positive TB test				Pain or pressure in chest				Loss of finger or toe			
Blood in sputum or when				Chronic cough				Painful or "trick" shoulder or elbow			
Coughing				Palpitation or pounding heart				Recurrent back pain or any back injury			
Excessive bleeding after injury or dental work				Heart trouble				"Trick" or locked knee			
Suicide attempt or plans				High or low blood pressure				Foot trouble			
Sleepwalking				Cramps in your legs				Nerve injury			
Wear corrective lenses				Frequent indigestion				Paralysis (including infantile)			
Eye surgery to correct vision				Stomach, liver or intestinal				Epilepsy or seizure			
Lack vision in either eye				Gall bladder trouble or gallstones				Car, train, sea or air sickness			
Wear a hearing aid				Jaundice or hepatitis				Frequent trouble sleeping			
Stutter or stammer				Broken bones				Depression or excessive worry			
Wear a brace or back support				Adverse reaction to medicine				Loss of memory or amnesia			
Scarlet fever				Skin diseases				Nervous trouble of any sort			
Rheumatic fever				Tumor, growth, cyst, cancer				Periods of unconsciousness			
Swollen or painful joints				Hernia				Parent/sibling with diabetes, cancer, stroke or heart disease			
Frequent or severe headaches				Hemorrhoids or rectal disease				X-ray or other radiation therapy			
Dizziness or fainting spells				Frequent or painful urination				Chemotherapy			
Eye trouble				Bed wetting since age 12				Head Lice			
Hearing loss				Kidney stone or blood in urine				Plate, pin or rod in any bone			
Recurrent ear infections				Sugar or albumin in urine				Easy fatigability			
Chronic or frequent colds				Sexually transmitted diseases				Been told to cut down or criticized for alcohol use			
Severe tooth or gum trouble				Recent gain or loss of weight				Used illegal substances			
Sinusitis				Eating disorder (anorexia, bulimia, etc...)				Used tobacco			
Hay fever or allergic rhinitis				Arthritis, Rheumatism, or Bursitis							
Head injury											
Asthma				Thyroid trouble or goiter							

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11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	
Treated for a female disorder						
Change in menstrual pattern						

Pregnancy exam must be conducted. Results - Negative ☐ Positive ☐

	YES	NO
12. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details)		
13. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred)		
14. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital)		
15. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic and details)		
16. Have you ever been diagnosed with a learning disability? (If yes, give type, where and how diagnosed)		

If you answered "yes" to any questions on page 1, use the space below to explain:

17. IMMUNIZATIONS (PHYSICIAN MUST ANNOTATE DATE OF IMMUNIZATION AND INITIAL)

Students **MUST** have the following immunizations for admittance into the Discovery ChalleNGe Academy

_____ **Tdap (Adacel within 10 years)**
Date

_____ **Seasonal Flu (January Class Only)**
Date

_____ **TB Test (Within 1 year of class start date)**
Date (If Positive please provide chest x-ray results)

_____ **HPV (Males and Females, Must begin series)**
Date

_____ **TB Results** _____ _____ _____
Date **NEG** **POS** **INITIALS**

_____ **MCV4 (Within 5 Years)**
Date **(Booster shot required if menactra shot was received before the age of 16)**

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

18a. TYPED OR PRINTED NAME OF EXAMINEE (STUDENT)	18b. SIGNATURE	18c. DATE

19. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA **(Physician shall comment on all positive answers. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)**

If History Of Asthma, is Inhaler Needed ☐ **Yes** ☐ **No** ☐ **N/A**

20a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER (Must be MD, DO, PA, NP)	20b. SIGNATURE	20c. DATE

Behavioral Health Requirement

If you have ever received counseling services, or have been hospitalized for counseling/ behavioral health reasons, please provide an evaluation report from the treating Therapist/Psychiatrist along with your application.

Below is a questionnaire to assist you in determining whether or not this is necessary documentation for you. If you answer yes to any of the below questions, you will be required to provide this documentation.

1. Have you ever been hospitalized for any counseling/ behavioral health reasons?

2. Have you ever been given a diagnosis from a treating Therapist/Psychiatrist? (i.e.: Depression, Bipolar Disorder, Conduct Disorder, Oppositional Defiant Disorder, etc.)?

3. Have you ever been prescribed medication for a diagnosis given to you by a treating Therapist/Psychiatrist, regardless of whether you took it or not?

This documentation is required so that the Counseling department may review it. Your application will not be processed until this information is included.

If you have any questions, please contact the Counseling department at (844) 633-3301