



# Ouachita Hills Academy

Office of Registrar

P.O. Box 35, Amity AR 71921

## HEALTH INVENTORY A: INSURANCE AND MEDICAL RELEASE (To be completed by parent)

Name of student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex:  Male  Female

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Who to notify in case of illness (Include address, phone numbers, and e-mails):

A) \_\_\_\_\_ B) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The student lives at home with:  Parents  Mother  Father  Guardian

Does the student have coverage by accident or hospitalization policy?  Yes  No

List all Health Insurance numbers (including dependent # in B.C.) and name of insurer:

Medical coverage: \_\_\_\_\_

Hospital Coverage: \_\_\_\_\_

Other coverage: \_\_\_\_\_

List any other serious illnesses, operations, or injuries and age when occurred: \_\_\_\_\_

\_\_\_\_\_

Has the student ever had an allergic reaction to certain drugs (please specify)? \_\_\_\_\_

List any allergies the student may have: \_\_\_\_\_

**Please Note:** Before the student enters school, all medical, dental, and eye work should be cared for.

**Signatures:** A) Both parents must sign unless one parent sends Proof of Custody, or a copy of a Death Certificate.

B) One parent must sign in the presence of a Notary Public.

"In the event of illness or accident, we, the undersigned parents or legal guardians of \_\_\_\_\_ (student's name), a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service which may be rendered to said minor under the general or special instructions any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the parent or guardian.

"It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Ouachita Hills Academy or the physician to exercise their best judgment as to requirements of the diagnosis or treatment. School officials are authorized to sign any necessary paperwork for us/me.

"This consent shall remain in continuous effect for the duration of this student's enrollment at Ouachita Hills Academy unless revoked in writing and delivered to the Ouachita Hills Academy Office.

"We hereby authorize any hospital, physician, or other medical personnel who has attended or examined the minor to furnish our insurance company, the school's insurance company, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records.

"A photocopy of this authorization shall be considered as effective and valid as the original."

Date: \_\_\_\_\_, Father or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_, Mother or Guardian: \_\_\_\_\_

State of: \_\_\_\_\_, County of: \_\_\_\_\_, Country: \_\_\_\_\_

[SEAL]

On \_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, before me, a Notary Public for the above

named County and State, appeared: \_\_\_\_\_ and \_\_\_\_\_

who is(are) known to me or whose Identity was proved with satisfactory evidence to be the Persons(s) whose Name(s) is(are) subscribed to this Instrument.

Signature: \_\_\_\_\_

NOTARY PUBLIC

Commission expires: \_\_\_\_\_