Student Health Registration and Consent for Medical Treatment
Upper Columbia Academy

Student Name _____ _____ _____ _____ _____
Last First Middle Gender Grade Birth Date Social Security #

Address: _____ Home Phone: _____
Street or PO Box City State/Province Zip Code

Student lives with: (Check one) Both Parents | Mother Only | Father Only | Mother & Stepfather | Father & Stepmother | Legal Guardian | Other: _____

Father's Name: _____ Mother's Name: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____
☐ OK to text to this cell phone number ☐ OK to text to this cell phone number

Father's Work Phone: _____ Mother's Work Phone: _____

Other Emergency contact: _____ Phone: _____
Name Relationship

Other Emergency contact: _____ Phone: _____
Name Relationship

Current Health History:

Please answer by checking:	No	Yes	Mild	Moderate	Severe	
Does student have vision problems?	☐	☐	☐	☐	☐	Contacts: ☐ Glasses: ☐
Does student have hearing problems?	☐	☐	☐	☐	☐	Hearing aid: ☐
Please check if student has any of the following:	**No**	**Yes**	**Mild**	**Moderate**	**Severe**	
Allergy to food:	☐	☐	☐	☐	☐	List: _____
Allergy to insects:	☐	☐	☐	☐	☐	Type: _____
Allergy to medications:	☐	☐	☐	☐	☐	List: _____
Asthma:	☐	☐	☐	☐	☐	
Diabetes:	☐	☐				
Heart problem: _____	☐	☐	☐	☐	☐	
Seizures, type: _____	☐	☐	☐	☐	☐	
ADD/ADHD:	☐	☐				

Has student had any serious injuries? ☐ ☐ If yes, explain: _____

Explain if other issues exist: _____

☐ No health problems to my knowledge

Does student take medications of any kind? No ☐ Yes** ☐ Please list: _____

_____

**Students requiring medication (prescription or non-prescription) while at school MUST have a written order by a Licensed HealthCare Professional and/or written parent consent. Please refer to the UCA medication policy for details. Forms are available from the school nurse and the Administration office.

Medical Consent (A photo copy of this authorization shall be considered as valid as the original.)

I, the parent/guardian of the above-named student, do hereby consent to any x-ray examination, immunization, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said student under the general or specific instructions of a physician, whether such diagnosis or treatment is rendered at the office of the physician or at a licensed hospital. It is further understood that consent is given in advance of any specific diagnosis or treatment that may be required. I authorize the designated staff of Upper Columbia Academy or a physician to exercise their best judgment as to the requirement of such diagnosis or treatment.

I hereby authorize any hospital, physician or other person who has attended to or examined the student to furnish the insurance service, 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. If the insurance company does not cover services, or I do not have insurance, I agree to take full responsibility for all financial obligations incurred during treatment and/or hospitalization of the student. Parents/Guardians are responsible for any co-payment at the time of service.

It is understood that reasonable effort will be made by Upper Columbia Academy and/or the attending physician to contact me prior to treatment so that the treatment necessary for the best interest of the above-named student may be given.

I authorize mental health professionals to release to Upper Columbia Academy any mental health/psychiatric and/or drug and alcohol assessment information that may pertain to the safety of the student or the school.

Parent/Guardian Signature _____ Date _____

I give my permission for UCA staff to discuss any medical conditions and/or medical needs that I have with my parents/guardians and with my medical providers.

Student Signature _____ Date _____

Please complete the medical insurance information on the back of this form and provide a copy of your medical insurance card.

Medical Insurance Information

Name of Student _____

Person(s) legally responsible for student's medical_____

Person(s) financially responsible for student's medical_____

Medical Insurance Company_____

Name of Policy Holder _____ Employer_____

Birth Date of Policy Holder _____ SS# of Policy Holder _____

Group # _____ Policy # _____

Is this a Preferred Provider Plan? _____ Does this plan require a referral from a Primary Care Physician?_____

P.C.P. or Family Physician_____ _____ _____
Name Phone Number Fax Number

Please include a copy of both sides of your medical insurance card and prescription card.

Questions about health forms or UCA medical policies can be directed to Cindy Williams, RN.

Cindy.Williams@ucaa.org
Phone: (509) 245-3616
Fax: (509) 245-3643
www.ucaa.org