(The following pages 10-15 may be completed after acceptance; but must be received before WCS can Issue an I 20)

Medical Information and Permission for Treatments

Student's Name _____Sex _____ DOB __/__/____ SSN# _____

Parent/Guardian responsible for medical treatment _____

Parent's Address _____

Parent's date of birth _____ Work phone _____Home phone _____

Please submit the following with this form:

- Current Immunization Certificate: up-to-date and signed by your child's doctor or your local health department

Health Insurance Information

Health Insurance is required before beginning school and is the financial responsibility of the international student.

Consent for Medical Treatment

I, the undersigned parent/legal guardian of _____, a minor, give my consent for Wesleyan Christian School staff to secure medical services including diagnosis and treatment in case of illness or injury. I agree to assume all financial responsibility for such services.

I also give my consent for any x-ray examination, anesthetic, medical or surgical diagnosis and/or treatment, and hospital care to be rendered to my child under the supervision and on the advice of a licensed medical professional; and for anesthetic, dental or surgical diagnosis and/or treatment, and hospital care to be rendered to my child by a licensed dentist.

I give consent for the exchange of pertinent medical/dental/surgical information between Wesleyan Christian School and any medical personnel involved in the care and treatment of my child and give permission for Wesleyan Christian School to obtain copies of medical records when they are pertinent to the continuing care of my child.

I authorize Wesleyan Christian School power of consent for all matter related to keeping immunizations up-to-date, including signing for any required immunizations.

I authorize Wesleyan Christian School consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist, licensed under the law.

In giving the consent, I recognize and understand that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me or the host family and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures. I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment from any available and to render such care and perform such treatment as he is his professional judgment determines to be necessary and to assume full responsibility for expenses incurred.

This consent shall remain effective as long as my child is a student at Wesleyan Christian School.

Signature _____ Date _____

I give permission to Wesleyan Christian School to administer over-the-counter medications to my child to address occasional symptoms such as headaches, cough, congestion, sore throat, or upset stomach and minor injuries.

Signature _____ Date _____

Health History (To Be Completed By Parent/Guardian)

Student Name _____ Date of Birth _____

Please list any significant family medical history _____

_____

_____

Please list any allergies, including food and drug allergies _____

Check any of the following conditions that the student has had in the past and/or currently has:

___ Allergies	___ Hypoglycemia	___ Hemophilia	___ Joint/Muscle Pain
___ Asthma	___ Menstrual Pain	___ Hearing Impairment	___ Heart Condition
___ Diabetes	___ Sleep Walking	___ Vision Impairment	___ Other
___ Epilepsy/Seizures	___ Bed Wetting	___ Frequent/Severe Headaches	

Please explain any above conditions _____

_____

_____

_____

List (give dates) of hospitalizations (including mental health and substance abuse treatment), operations, serious illnesses, serious injuries, etc. _____

_____

_____

_____

Is the student currently under a doctor's care? ___ Yes ___ No If so, what for? _____

_____

Please make sure your child has had a dental checkup in the last year. Date of last visit _____

Please list below current medications and purposes

Medication	**Purpose**
_____	_____
_____	_____
_____	_____

*Ongoing medications MUST be monitored by a home physician.

A Permission to Administer Medication Form must be completed at the time of enrollment and whenever leaving medication for your child at Wesleyan Christian School. Parents are responsible to make certain that prescription refills are sent to host family as needed.

Physical Examination (To be completed by student's physician or primary healthcare provider)

Student Name _____ Date of Birth _____

Date of Exam _____ How long have you attended this person? _____

_____ Height _____ Weight _____ Temperature _____ Pulse

_____ Blood Pressure _____ Vision _____ Hearing

Normal		**Abnormal**	**Remarks**
_____	Face and Skin	_____	
_____	Eyes	_____	
_____	ENT	_____	
_____	Teeth	_____	
_____	Neck, Thyroid	_____	
_____	Lymph nodes	_____	
_____	Chest	_____	
_____	Heart	_____	
_____	Lungs	_____	
_____	Abdomen	_____	
_____	Hernia	_____	
_____	Extremities	_____	
_____	Neurological	_____	

Are all required immunizations up-to-date (physician verification is required for enrollment)? _____

When is (are) next shot(s) due? _____

Describe any abnormality including emotional disturbances which should be known to WCS personnel.

_____

_____

Is there any reason to suspect that this student has been involved with drug or alcohol abuse? _____

_____

Are there any restrictions to physical activity/physical education classes? _____

If yes, please explain _____

Do you have any concerns about this student being away from home in a home stay environment?

_____

_____

If you wish WCS personnel to continue with some medications or treatments you have been giving, please attach your orders.

Physician's signature _____

Physician's Name (please print) _____

Physician's Address _____

Physician's phone _____ Physician's fax _____

A current immunization certificate completed or translated in English signed by doctor or health department must be attached.