

# Rice Memorial High School

## Medical Information Form

Please complete the following sections of information and include with your registration form.

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### Biographical Information

Student Name

\_\_\_\_\_  
(Last) (First) (DOB) (Yr Grad)

Emergency Contact

\_\_\_\_\_  
(Name) (Phone) (Relationship)

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### Physician Information

Physician's Name

Last Exam\_\_\_\_\_

\_\_\_\_\_  
(Last) (First) (Phone)

Dentist's Name

Last Exam\_\_\_\_\_

\_\_\_\_\_  
(Last) (First) (Phone)

Specialist's Name(s)

Last Exam\_\_\_\_\_

\_\_\_\_\_  
(Last) (First) (Phone)

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### Vision Information

Ophthalmologist-Optometrist Name

\_\_\_\_\_  
(Last) (First) (Phone)

Do you wear glasses? Y N Do you wear contact lenses? Y N

Please list any eye problems; (i.e. muscle injury, surgeries, infections, etc.)\_\_\_\_\_

Are there any vision-related classroom accommodations needed? Y N If so, please explain:\_\_\_\_\_

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### Hearing Information

Otolaryngologist's Name

\_\_\_\_\_  
(Last) (First) (Phone)

Do you use hearing aids or other devices? Y N If yes, please list: \_\_\_\_\_

Please list any ear problems; (i.e. ear injury, surgeries, infections, etc.) \_\_\_\_\_

Are there any hearing-related classroom accommodations needed? Y N If yes, please explain: \_\_\_\_\_

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### Hospitalizations

Date Reason

Date Reason

Date Reason

Date Reason

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### Physical Activity

Do you have any physical conditions or limitations? Y N If yes, please explain: \_\_\_\_\_

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### Medications

Date Reason

Are you currently on any medications? Y N If yes, please list medications and reason: \_\_\_\_\_

Medication Reason

Medication Reason

The permission form in the Student Handbook must be completed for all prescription and non-prescription medication to be taken at the school.

Have you ever experienced any social, emotional or physical problems, which may affect behavior at school? Y N

If yes, please explain: \_\_\_\_\_

## Immunization Record

It is a Vermont statute that all high school students have up-to-date immunization records on file before the start of each school year. Please record below, the dates of immunization or provide a copy from your physician. Record in MM/DD/YY.

Immunization	Date	Date	Date	Date	Date
DT Pediatric Diphtheria, Tetanus					
TD Adult Tetanus, Diphtheria					
Tetanus – Note Type					
MMR – Measles, Mumps, Rubella					
Polio – Note Type					
Measles					
Rubella					
Mumps					
Chicken Pox					
HIB – Note Type					
Tuberculin					
Hepatitis B					
Other					

Has a physician ever diagnosed you with measles?    Y    N    If yes, when: \_\_\_\_\_

Medical Exemption?    Y    N    If yes, please attach a signed statement from your physician.

Religious Exemption?    Y    N    If yes, please attach a signed statement from parents.

Moral Exemption?    Y    N    If yes, please attach a signed statement from parents.

### Other Significant Medical History

In reviewing the following checklist, please provide additional information for each “yes” response.

Health Problem	Y or N	If Yes, please explain.	Medication Taken
Asthma-Bronchial-Respiratory			
Allergies(Please list)			
Bleeding or Anemia			
Chicken Pox			
Diabetes			
Fainting-Dizziness-Blackouts			
Fractures-Sprains-Muscle Tear			
Heart Condition			
Hepatitis			
Kidney-Bladder Problems			
Operations			
Seizures			
Are there smokers in household			
Menstrual Problems			
Frequent Headaches-Migraines			
Other			

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_