MAUR HILL – MOUNT ACADEMY
RESIDENCE LIFE HEALTH INFORMATION – BOARDING STUDENTS

Student Name:_____ Date of Birth _____/_____/_____ (MM/DD/YYYY)

Health Concerns
Please list all **allergies** (including medication) as well as any health related, other problem or past medical history that would be pertinent to someone treating your child. (Use and submit additional paper if needed.)

_____

Health History - Use the following check list to indicate if your child has or had:

_____ Convulsions or seizures	_____ Malaria	_____ Diabetes	_____ Other
_____ Asthma	_____ Depression	_____ ADD/ADHD	
_____ Heart problems	_____ Drug or alcohol abuse	_____ Hepatitis	_____

Parent's/Guardian's Names: _____
Family Physician _____ Tel. _____
Emergency Contact: MH-MA Residence Director Tel. 913 - 367 – 5482

Turn in all medications with directions to the Residence Director. List medications here:

_____

Medications must be under control of residence life and are not allowed in a student's possession. This form grants Maur Hill - Mount Academy residence staff permission to dispense non-prescription medicines. (e.g., Tylenol, cough drops, and similar over the counter medication) and prescriptions as issued by medical professional.

U.S. Residents: Submit copy of insurance card and the below information that accompanies it.
Insurance Card holders DOB _____/_____/_____ (MM/DD/YYYY); **SS # of Card Holder** _____ -____-_____
***International Students: Insurance is included in tuition cost.**

All Students: Provide current copy of immunization (vaccine) records.
Dental Examination: Last date of dental check up _____/_____/_____ (MM/DD/YYYY)

I give permission authorizing Maur Hill-Mount Academy to arrange for Medical, Dental, Psychological/therapeutic and Mental Health Care when it is deemed necessary and to be able to discuss the findings and treatment with the attending medical personnel. I release MH-MA from any liability which might arise from giving such authorization. In the course of student activities both on and off campus, there is occasionally a need to take a student for emergency medical treatment. School officials will try to reach parents of the student concerned so that permission for treatment can be given by them. Sometimes parents are not available and school officials feel that treatment, as deemed necessary by the attending physician, should be approved. **Therefore, we ask parents/legal guardians to grant Maur Hill - Mount Academy administrators, coaches, and residency center personnel permission by signing below to approve emergency medical treatment deemed necessary by the attending physician.**

X _____ Tel. _____-_____-_____
Parent/Legal Guardian Signature

Atchison Hospital Association (Acknowledgment of Receipt of Privacy Notice)
I acknowledge that I have read a copy of Provider's Notice of Privacy Practices on the Atchison Hospital website www.atchisonhospital.org. (Paper copy of Privacy Policy is available upon request.)

X _____ Today's Date_____/_____/_____ (MM/DD/YYYY)
Parent/Legal Guardian Signature

_____ Date of Birth_____/_____/_____(MM/DD/YYYY)
Patients Name