DOMINION
ACADEMY OF DAYTON

Student Health & Medical Record

To be filled out annually by parent or guardian. Please print in ink. Date_____

Student name_____ Date of Birth_____Sex_____

Parent(s)/Guardian(s)_____

Home Address_____City, State, Zip_____

Home Phone:_____

Father's/Guardian's work _____ Father's/Guardian's cell_____

Mother's/Guardian's work _____ Mother's/Guardian's cell_____

Father's email _____ Mother's email _____

If persons named above are not available in the event of an emergency, notify:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name of personal physician_____Phone_____

Hospital preference:_____

Please include instructions about special medical needs, food allergies, or current medications child is taking:

_____

_____

Revised 12/13/2017

Personal health/accident insurance carrier_____

Policy No._____ Group No._____

☐ A copy of my insurance card is attached. (Required, if applicable)

Date of last tetanus immunization _____

In case of an emergency, I understand every effort will be made to contact me (or my spouse or next of kin). In the event that I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by a school official in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Signature of parent/guardian _____Date_____