# Fordham Preparatory School

Ecuador Service Immersion Trip
Medical/ Health Questionnaire

Student:_____ Date:_____

Parent's Name: _____ Home Phone:_____

Cell Phone: _____

Work Phone: _____

Home Address: _____

Physician's Name:_____ Phone #:_____

Physician's Address_____

Emergency Contact_____ Phone #_____

Does/Has your son have/had a disease(s) that affects the function of eye, ear, kidney, or lung? _____ If yes, briefly explain:_____

List any operations, fractures, sprains or bone dislocations:

_____ Date or age_____

_____ Date or age_____

_____ Date or age_____

3) Has your son ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Y | N | Mononucleosis | Y | N |
| Fainting and/or Convulsions | Y | N | Pneumonia | Y | N |
| Heart Murmur/Heart Condition | Y | N | Hepatitus | Y | N |
| Rheumatic Fever | Y | N | Bronchitis | Y | N |
| Kidney Disease or Injury | Y | N | Head Injury | Y | N |
| Heat Stroke/ Heat Exhaustion | Y | N | Concussion | Y | N |
| Diabetes | Y | N | Seizure | Y | N |
| Blood disorders | Y | N | Tumors | Y | N |
| Arthritis and/or Joint Redness | Y | N | Serious Dental Problems | Y | N |
| Bridges or False Teeth | Y | N | Reaction to insect bites | Y | N |

Allergies:

Please list: _____

Any other serious illness or injury?_____

Please explain yes answers to above questions:_____

Does your son take any medication now?_____ If so what?_____

Does your son where glasses or contact lenses? _____ Yes _____ No

Are there any medications your son cannot take?_____ Yes _____ No

if yes, explain:_____

I give my son permission to participate in the Service Immersion Trip to Ecuador. I I hereby request that the Faculty or Administration of Fordham Prep act on my behalf if during the program a medical emergency develops and and some decision regarding my son's health must be made immediately. In addition, I understand that any treatment authorized by Fordham Prep or its teacher's shall be at my sole cost and expense and the authorization of said treatment by any of the above shall be by them as my agent for my son.

Parent Signature:_____

Date:_____

INSURANCE INFORMATION

Name of Medical Insurance Plan: _____

Membership ID #:_____

Phone #:_____

Address: _____