

GOODLAND ACADEMY

1216 N 4200 RD • Hugo, Oklahoma 74743 • (580) 326-7568 • fax (580) 326-5556

email: admission@goodland.org • website: www.goodland.org

MEDICAL INFORMATION

Does your child wear glasses or contacts? _____
 If yes, when are they required? All of the time? _____ Reading only? _____
 Has your child ever been hospitalized? _____ If yes, please explain. _____

Has your child ever broken a bone? _____ If yes, please explain. _____

Is your child allergic to any of the following? If yes, please describe. _____

- | | | |
|-------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Nuts | <input type="checkbox"/> Other |

Does your child have any physical limitations that would prevent them from hiking, carrying a pack, etc.? If yes, please explain. _____

Does your child currently have, or has experienced in the past year, any of the following (please check all that apply):

Dizziness or fainting spells	Constipation or diarrhea
Frequent or migraine headaches	Pain or bleeding during bowel movements
Skin allergies or rashes	Unexplained weight change
Warts or sores on feet	Rheumatism
Chest pain or shortness of breath	A rupture or hernia
Spitting or coughing up blood	Pain in back, neck, or joints
Sweating at night	Difficulty walking, running, or lifting
Stomachaches, or indigestion	Diabetes or sugar in urine
Arthritis	Venereal disease
Excessive bleeding	Tumor, growth, cyst, or cancer
Hemophilia	A knee or ankle injury
An ulcer	Rheumatic fever
A back injury or deformity	Mumps
Anemia	Chicken Pox
Scarlet Fever	Pneumonia
Seizures, convulsions	Typhoid
Kidney disorders	Appendicitis
Ear infection	Polio
Measles	Frequent colds

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FOR FEMALES ONLY

<input type="checkbox"/>	Heavy menstrual periods	<input type="checkbox"/>	Menstrual periods longer than eight days
<input type="checkbox"/>	Painful menstruation		

Explanation for any conditions checked above (if necessary): _____

List any other significant illness, problems, diseases, or disorders not listed above: _____

IMMUNIZATIONS

Please note the date of the following:

Diphtheria-Pertussia-Tetanus (DPT) _____
or Diphtheria-Tetanus (DT) _____
or Tetanus Toxoid _____

Measles, Mumps, Rubella (MMR) _____

EMOTIONAL

Has your child ever been hospitalized for a psychiatric/psychological reason? _____
If yes, when and where? _____

Has your child ever been diagnosed with any mental disorders? _____ If yes, complete the following:

Diagnosis _____ When diagnosed _____
Psychiatrist _____ Phone number _____

Has your child ever been diagnosed with any psychiatric disorders (ODD, depression, anxiety, etc.)?
If yes, explain. _____

Has your child been diagnosed with AD(H)D? _____

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MEDICATIONS

Is your child currently taking any over-the-counter medications? _____ If yes, please explain.

If this medication needs to continue while your child is at Goodland, a supply of the medication, with instructions and dosages, will need to be sent with your child at the time of admission.

Has your child previously taken prescription medications other than current medications? _____
If yes, please explain. _____

PRESCRIPTION MEDICATIONS

If your child is currently taking medications, please do the following:

- Send at least a 30-day supply of the medication. Keep all medications in their original prescription bottles.
- If your insurance will not allow you to obtain a 30-day supply of medication, you will need to refill the medication while your child is at Goodland and send the medication to us. Prescriptions cannot be refilled at Goodland, but can be refilled locally at several national chain pharmacies.
- If your child is using an inhaler, please send two inhalers.
- Include copies of any literature/instructions you have on the medications for our files.

Medication Name _____ mg. _____ Dosage Schedule _____

Starting date _____ Ending date (if applicable) _____

Name of prescribing physician _____ Phone number _____

Why medication is being taken _____

Any side effects _____

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Please attach a copy (include both sides) of your child's insurance/medical card.