

# Confidential student health history

Cushing Academy Admissions Office tel: (978) 827-7300  
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**To be completed by primary care physician**

Your patient will be attending Cushing Academy. Medical information is required in order for our Health Center to properly care for the students. (This Health History is held on file at the Health Center and is accessible to the medical staff only.)

Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
FIRST MIDDLE LAST MONTH/ DAY/ YEAR

1. Do you consider this student to be in good health?  Yes  No
2. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Allergies: \_\_\_\_\_
3. A. Significant past medical history (major illnesses, trauma, head injuries, etc.)  
 B. Recurring medical problems (include treatment plan) i.e.: asthma (baseline peakflow), otitis, GI
4. Musculoskeletal History: \_\_\_\_\_
5. Sports Restrictions: \_\_\_\_\_
6. Significant Family Medical History: \_\_\_\_\_
7. If either of these are answered **yes**, please elaborate in a separate letter or on a separate sheet to the Health Center. Such information is treated in confidence except in the case of medical or surgical emergency.  
 A. Has the student had any individual problems of learning or emotional and social adjustment?  Yes  No  
 B. Has the student ever received psychological care?  Yes  No
8. Has the student had chickenpox?  Yes  No  
 If yes, month and year of illness \_\_\_\_ / \_\_\_\_ **If no, vaccine required.**
9. Are there any abnormalities of the following systems?

	YES	NO	COMMENTS	LIST PRESCRIPTION MEDICATIONS DRUG TYPE/ DOSE /DX / PRESCRIBING PHYSICIAN
Head, ears, nose, throat				
Hearing				
Respiratory				
Cardiovascular				
Gastrointestinal				
Hernia				
Eyes				
Genitourinary				
Musculoskeletal				
Metabolic/Endocrine				
Neuropsychiatric				
Skin				
Other				

**Prescription medications must be registered with the Health Center**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_