

The New ERA Enrichment & Recovery Academy



CERTIFICATE OF HEALTH

Student's Name: _____
(First) (Middle) (Last)

Date of Birth: _____

Parent(s)/Guardian(s): _____

Address: _____

_____ Zip _____ Country _____

Home Telephone (_____) _____

Business Telephone (_____) _____

(_____) _____

Cell Phone (_____) _____

Physical Exam Must Be Current - Within 3 Months Prior to Enrollment at ERA.

Important! Health regulations of Missouri Military Academy, the ERA – Enrichment & Recovery Academy, and the laws of the State of Missouri require cadets to have a physical examination, and to have a complete Certificate of Health and Medical Emergency Treatment Form on file at the Cadet Hospital prior to attendance.

The Certificate of Health is to be completed by the family and the family physician. Students are accepted with the understanding that they are in good health and can participate in the entirety of the ERA program.

Cadets who take medication or are in need of continuing medical treatment must have written physician instructions on file in the Cadet Hospital. (Medications provided from home must have a pharmacy label with the date, name of the patient, name of the medication, instructions to dispense and name of the physician.) **Controlled medications must be delivered to the ERA Cadet Hospital in person by the parent or guardian or sent by mail directly to the Cadet Hospital prior to attendance.** ERA will not be responsible for the accuracy and safety of any medications not provided by area pharmacies.

Major allergies and sensitivities must be enumerated by the examining physician on the Certificate of Health.

PHYSICAL EVALUATION: TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER

STUDENT'S NAME _____

Height _____ Weight _____ Blood Pressure _____ Hair Color _____ Eye Color _____

	NORMAL	ABNORMAL	COMMENTS
Skin _____			
Nose _____			
Throat _____			
Teeth _____			
Cardiovascular _____			
Gastrointestinal _____			
Genito-Urinary _____			
Neurological _____			
Muscular Skeletal _____			
Scoliosis Screening _____			
Nutritional Status _____			
Allergies to Medications _____			
Regular/Routine Medications _____			

1. Operations, with dates _____ Any sequelae? _____

2. Injuries, with dates _____ Any sequelae? _____

3. Any allergic condition? _____ Hay fever? _____ Asthma? _____ Eczema? _____

4. Has the boy been under a physician's care within the past two years? _____ Why? _____

5. Has the boy had a positive reaction to testing for or been treated for Acquired Immune Deficiency Syndrome or AIDS Related Complex? _____

6. Has the boy ever been in consultation with any doctor/counselor concerning emotional or psychiatric problems? _____ Hospitalized? _____ If so, describe _____

7. Has the boy ever been in consultation with a doctor/counselor concerning any controlled substance? _____ If so, describe. _____

◆ **Physician's Signature** _____
 Address _____

Telephone (____) _____ **Date** _____

IMMUNIZATION RECORD

Type of Vaccine and Dose Number: Insert month, day and year immunization was received in the appropriate space. Immunization dates should be taken only from a statement or record of a physician or other recognized health facility or personnel.

Disease History: Please note that for camp and school attendance, disease history must be documented by laboratory evidence of immunity. If no documentation is available, the boy should be immunized.

Adverse Reactions: Record type of vaccine, the date of reaction and symptoms.

Action Taken: To be used for notes relating to immunization history.

Students entering ERA – Enrichment & Recovery Academy must have been immunized in accordance with the following criteria, which are required by the Missouri State Board of Health. **It is mandatory that every student attending an ERA program receive a PPD Tuberculin Test within three months prior to enrollment.**

IMMUNIZATION RECORD

Vaccine	Date Given m/d/y	Site*	Source of Vaccine** (F,S,P)	Vaccine Manufacturer	Vaccine Lot #	Vaccine Information Materials Pub. Date	Initials
DT DTP 1							
DT DTP 2							
DT DTP 3							
DT DTP DTaP4							
DT DTP DTaP5							
DTP-Hib 1							
Td 1							
Td 2							
OPV IPV 1							
OPV IPV 2							
OPV IPV 3							
OPV IPV 4							
MMR 1							
MMR 2							
Hep B 1							
Hep B 2							
Hep B 3							
PPD							

Site Given Legend: RA=Right Arm; LA=Left Arm; RT=Right Thigh; LT=Left Thigh; 0=Oral**Source of Vaccine Legend: F= Federal; S=State; P=Private

The New ERA

Enrichment & Recovery Academy



MEDICAL EMERGENCY TREATMENT FORM

The Cadet Hospital at MMA is capable of administering medical treatment for almost all occurrences of injury or sickness; however, from time to time, it is necessary to admit cadets to local hospitals.

Our local hospitals have agreed to accept this form, insuring there will be no delay in admission of your child to a local hospital. In an emergency, you will be contacted by telephone at the earliest possible time. By signing this form, you are granting permission to the Cadet Hospital medical staff to treat your child.

In case of emergency, I understand every reasonable effort will be made to contact the parent(s) or guardian(s) of the student. In the event I cannot be reached, I hereby give permission to the ERA – Enrichment & Recovery Academy physician or any physician selected by the ERA – Enrichment & Recovery Academy to hospitalize, secure proper treatment for and order injections, anesthesia, or surgery for, and release medical information to such members of the faculty and staff of ERA as have need to know, concerning:

Name of Student: _____ **Date of Birth** _____

Social Security Number: _____

Allergies to medications: _____

Date of last tetanus booster: _____

Name of Parent(s)/Guardian(s): _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Business Phone:** _____

I authorize release of medical information on my son/ward to such members of the faculty and staff as have a need to know.

◆ **Parent(s)/Guardian(s) Signature:** _____

◆ **Student Signature:** _____

Date: _____

Emergency contact other than parent/guardian:

Name: _____ **Relation:** _____

Home Phone: _____ **Business Phone:** _____

(PLEASE BE SURE TO ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARD TO THIS FORM)

This form must be on file at ERA prior to attendance. In the event you have any questions concerning this form, please call the ERA Cadet Hospital at 573.581.1775.

° Note to Parent(s)/Guardian(s): This form is necessary to ensure that your son receives immediate medical treatment in the case of emergency is required by Audrain Medical Center, Mexico, Missouri, or any other licensed health care provider or facility is a release from the Privacy of Information Act. If you have any questions concerning the admissibility of signing such a document, it is suggested that you consult your physician. This form is MANDATORY and must be received before the start of the summer school session in order for your child to be eligible for treatment at the ERA Cadet Hospital.