

The New ERA

Enrichment & Recovery Academy



*On the campus of
Missouri Military Academy*

CERTIFICATE OF HEALTH

STUDENT INFORMATION

First Name	Middle Name	Surname or Family Name	Other
Birthdate (MM/DD/YYYY)	Age	Social Security Number (USA) or Passport Number	

PARENT/GUARDIAN INFORMATION

Parent/Guardian			
First Name	Middle Name	Surname or Family Name	Other
Mailing Address: # and Street (please include all numbers, etc.)			
City, State		Country	Zip or Postal Code
Home Phone	Cell Phone	Contact Email Address	

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

Important! Health regulations of Missouri Military Academy, The New 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 (page 4 of this form) on file at the Cadet Clinic 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 New ERA program.

Students who take medication or are in need of continuing medical treatment must have written physician instructions on file in the Cadet Clinic. (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 New ERA Clinic in person by the parent or guardian or sent by mail directly to the Cadet Clinic prior to attendance.** The New 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 EXAMINATION

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Date of Exam (MM/DD/YYYY): ____/____/20____

STUDENT INFORMATION

First Name	Middle Name	Surname or Family Name	Other

Height:	Weight:	Blood Pressure:	Hair Color:	Eye Color:
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Evaluation	Normal	Abnormal	Comments
Skin			
Nose			
Throat			
Teeth			
Cardiovascular			
Gastrointestinal			
Genital-Urinary			
Neurological			
Muscular Skeletal			
Scoliosis Screening			
Nutritional Status			

Does student have any allergies to foods, medications, other? Hay fever, Asthma, Eczema? If so, please list.


Does student take any daily/regular/routine medications? If so, please list.

Has the student been under a physician's care within the past two (2) years? If so, please describe.

Has the student any surgical procedures, significant injuries? Any reoccurrences? If so, please describe.

Has the student had a positive reaction to or been treated for HIV? If so, please describe.

Has the student in consultation with any doctor or counselor concerning use of controlled substances, emotional and psychiatric problems? If so, please describe.

Signature of Examining Medical Professional	Name of Business, Clinic or Facility	
		
Address	City, State	Zip or Postal Code

IMMUNIZATION RECORD

The New ERA

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STUDENT INFORMATION

First Name	Middle Name	Surname or Family Name	Other

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.

ATTENTION: Students entering The New ERA – Enrichment & Recovery Academy must have been immunized in accordance with the following criteria, which are required by the Missouri State Board of Health. If your student has not received the required immunization(s) prior to entering the Missouri Military Academy, the Academy will complete his immunizations. I hereby authorize Missouri Military Academy to complete all required immunizations. I understand that I will be charged for this service.

YES  Parent Signature: _____ **← SIGN HERE**

Vaccine	Date Given mm/dd/yy	Site*	Source of Vaccine** (F, S, P)	Vaccine Manufacturer	Vaccine Lot#	Vaccine Info <small>Materials Pub. Date</small>	Initials
DT DTP 1							
DT DTP 2							
DT DTP 3							
DT DTP DTaP4							
DT DTP DTaP5							
DTP-Hib 1							
TdaP							
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

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MEDICAL EMERGENCY TREATMENT FORM

The Cadet Clinic 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 Clinic 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 New ERA – Enrichment & Recovery Academy physician or any physician selected by The New 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 The New 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 child 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 The New ERA Clinic prior to attendance. In the event you have any questions concerning this form, please call the ERA Cadet Clinic at 573.581.1775.

° Note to Parent(s)/Guardian(s): This form is necessary to ensure that your child 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 New ERA Cadet Clinic.