Health History and Medical Form
Art academy of Cincinnati, Counseling/Learning Assistance Center

PLEASE COMPLETE ALL PARTS OF THIS FORM AND RETURN BY **JULY !st**
TO:
Karen Mendenhall, LISW-S Counselor/Learning Assistance Coordinator
Art Academy of Cincinnati, 1212 Jackson Street, Cincinnati, Ohio 45202

NAME_____
DATE OF BIRTH_____
COUNTRY OF CITIZENSHIP_____
VISA STATUS_____
PERMANENT ADDRESS_____
CITY/STATE/ZIP CODE_____
TELEPHONE: HOME_____**CELL**_____
EMAIL_____

FATHER'S NAME_____
ADDRESS_____
TELEPHONE: HOME_____**WORK**_____**CELL**_____
MOTHER'S NAME_____
ADDRESS_____
TELEPHONE: HOME_____**WORK**_____**CELL**_____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:
NAME_____
TELEPHONE: HOME_____**WORK**_____**CELL**_____

PHYSICIAN'S NAME_____
OFFICE ADDRESS_____
OFFIE PHONE NUMBER_____

PRIMARY HEALTH INSURANCE NAME_____
INSURANCE POLICY ID NUMBER_____
EFFECTIVE DATE OF COVERAGE_____

STUDENT SIGNATURE_____**DATE**_____

PERMISSION IS GRANTED TO REFER THIS STUDENT TO A DULY LICENSED PHYSICIAN, SURGEON OR DENTIST FOR NECESSARY EMERGENCY TREATMENT WHEN INDICATED, INCLUDING ADMISSION TO HOSPITAL FACILITIES. PARENT OR GUARDIAN MUST ALSO SIGN IF THE STUDENT IS UNDER 18 YEARS OF AGE AT THE TIME THIS MEDICAL INFORMATION IS SUBMITTED.

PARENT SIGNATURE (if student is a minor)_____**DATE**_____

HEALTH HISTORY

1. **Do you have any chronic medical, physical, or mental condition that might affect your class attendance or participation at the Art Academy of Cincinnati? _____ Yes _____No**
   If yes, please explain:

2. **Have you ever consulted with a psychiatrist, psychologist, or other mental health specialist? _____Yes _____No**
   If yes, please give dates and explain:

3. **Have you ever consulted with a neurologist? _____Yes _____No**
   If yes, give dates and explain:

4. **Have you ever received testing for a suspected learning disability?**
   _____ Yes _____ No
   If yes, give name of person seen, dates and results:

IF YOU ANSWERED YES TO ANY OF QUESTIONS 1-4, PLEASE FILL OUT THE ATTACHED SPECIAL ACCOMMODATIONS FORM FOR SPECIAL ASSISTANCE. THE USE OF SPECIAL ACCOMODATIONS AT AAC WILL REQUIRE DOCUMENTATION FROM A TREATING PHYSICIAN OR SPECIALIST (see attached guidelines) IN ACCORDANCE WITH UNITED STATES, SECTION 504 OF THE REHABILITATION ACT OF 1973 AND THE AMERICANS WITH DISABILITIES ACT (ADA).

Revised 4/15/2013

What medications, if any, are you currently taking?

Medication	Dosage	Reason Prescribed

Any Known Allergies?_____

_____

_____

Have you ever received adrenaline for an allergic reaction?_____Yes _____No

Past Hospitalizations (Medical, Psychiatric, Substance Abuse_

Date	Reason	Hospital

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HOUSING HEALTH HISTORY FORM

Fill this form out if you are staying in the AAC Housing Facility ONLY

Name_____
Date of Birth_____

I, the undersigned student (if over 18 years of age) or parent (if student is under 18 years of age), have read and understand the information provided to me about Meningococcal Meningitis and Hepatitis B. I understand the benefits and risks of being vaccinated against these diseases. The information below regarding my vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133 (B).

Meningococcal vaccine received? _____**Yes** _____**No**
If yes, please give date_____

Hepatitis B vaccine received? _____ **Yes** _____**No**
If yes, please list the date
1st dose_____
2nd dose_____
3rd dose_____

Student Signature_____**Date**_____
Parent Signature (if student is under 18 years of age)_____**Date**_____

Revised 4/15/2013