



MEDICAL APPLICATION FORMS

INSTRUCTIONS

1. All Medical Application Forms must be completed in English and all supporting documents must be supplied in English
2. All Medical Application Forms must be filled in by hand, scanned and sent by email to our Registrar - **admissions@utphighschools.com**
3. The Medical Application Forms include:
 - Immunization / Physical Examination Consent Form
 - Immunization Form
 - Health History & Physical Form
 - Over the Counter (Common) Medication Administration Consent
4. Students are required to bring all ORIGINAL Medical Application Form documentation with them for orientation.
5. **Any student without the original Medical Application Form paperwork at orientation will not be permitted to start classes.**

IMMUNIZATION & PHYSICAL EXAMINATION CONSENT FORM

IMMUNIZATION CONSENT (REQUIRED IMMUNIZATIONS)

I have had the opportunity to ask questions about the immunization(s) needed and offered to

Student's Family Name, Given Name

and have been informed of the risks and benefits of the vaccination(s) required for compliance with state laws. I further understand that UTP can make arrangements to administer these vaccinations for our convenience, and I agree to hold UTP and its employees harmless from liability for personal or bodily injury that may result because of the administration of any vaccine.

I am authorized to and do give permission for medical personnel to administer the required immunization(s) to

Student's Family Name, Given Name

during scheduled Immunization Days.

I also understand that there is a cost for all immunizations and that my student is responsible for bringing cash, credit card, or a check to school on the date of each Immunization Day, to pay UTP for any received immunization(s).

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y

IMMUNIZATION CONSENT (OPTIONAL IMMUNIZATIONS)

IF YOU WISH TO HAVE YOUR CHILD IMMUNIZED AGAINST THE FOLLOWING DISEASES, PLEASE PLACE YOUR SIGNATURE ON THE LINE NEXT TO EACH VACCINE. THESE ARE NON-MANDATORY BUT ARE HIGHLY RECOMMENDED BY THE CDC:

HEPATITIS A: (Two dose series)

A food borne illness that can last for several weeks with symptoms of diarrhea, vomiting and fever. Vaccine usually provides lifetime immunity.

Most common side effect - soreness at injection site.

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y

HUMAN PAPILLOMA VIRUS (HPV): (Three dose series).

Prevents cervical cancer in girls and head, neck, anal and penile cancer in boys.

Most common side effect - soreness at injection site)

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y



MENINGITIS B: (Two dose series)

Infection of the lining of the brain and spinal cord. Protects against meningococcal disease caused by serogroup B. (This is different than the Menveo/Menactra mandatory vaccine that protects against serogroups ACWY). College students are more at risk for this disease. 80% of meningitis cases in 18-23 year olds are Meningitis B. Certain colleges are already mandating this vaccine.

Most common side effects - injection site pain, fatigue, headache and joint pain.

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y

INFLUENZA: (Yearly dose)

Serious illness which includes fever, body aches, sore throat, coughing, and can also lead to pneumonia. Child may miss 1-2 weeks of school.

Most common side effects - mild aches, fatigue.

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y

COVID 19

Serious respiratory disease spread mainly from person to person.

Most common side effects - fever, body aches, chills, tiredness.

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y

PHYSICAL EXAMINATION CONSENT

I understand that for enrollment and continued study in a UTP school, my student must receive a physical examination by a certified physician approved by the school. I understand that an additional physical may be required if my student intends to play a sport during their time in the United States. These exams are compliant with state standards and valid for one year through the last day of the month dated

I am authorized to and do give permission for medical personnel to administer the required physical examinations to

Student's Family Name, Given Name

during scheduled Physical Examination days.

I also understand that there is a cost for physical examinations, and that my student is responsible for bringing cash, credit card, or a check to school on the date of each Immunization Day, to pay UTP for any received immunization(s).

Parent/Guardian Name	Date	M M	D D	Y Y
Signature of Parent/Guardian	Date	M M	D D	Y Y



MEDICAL CERTIFICATE OF IMMUNIZATIONS

(Required by state laws)

Student's Family Name			Student's Given Name(s)		
Date of Birth	MM	DD	YY	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address					
State/Province			Zip/Postal Code		
Country of Birth			Telephone Number		

Please print month, day, & year for each immunization below:

PPD Test: Date Placed		MM	DD	YY	Date Read:	MM	DD	YY	Result								
Important: Student may be denied entry to school without proof of PPD If PPD skin test result is positive, a negative chest X-ray result must be submitted																	
DtaP: 1	MM	DD	YY	2	MM	DD	YY	3	MM	DD	YY	4	MM	DD	YY	(3 mandatory)	
DtaP/Td Booster:	MM	DD	YY														
Tdap:	MM	DD	YY	(Boostrix or Adacel)													
Polio (OPV/IPV): 1	MM	DD	YY	2	MM	DD	YY	3	MM	DD	YY	4	MM	DD	YY		
MMR: 1	MM	DD	YY	2	MM	DD	YY										
Hepatitis B: 1	MM	DD	YY	2	MM	DD	YY	3	MM	DD	YY						
Meningococcal ACWY (MCV4) (Menveo or Menactra): 1	MM	DD	YY	2	MM	DD	YY	(one dose must be at 16 years of age or older)									
Varicella: 1	MM	DD	YY	2	MM	DD	YY	OR - History of disease date: MM DD YY									

Optional vaccines not mandatory, but recommended by CDC:

Hepatitis A: 1	MM	DD	YY	2	MM	DD	YY							
Human Papillomavirus (HPV): 1	MM	DD	YY	2	MM	DD	YY	3	MM	DD	YY			
Meningitis B (Trumenba or Bexsero): 1	MM	DD	YY	2	MM	DD	YY	3	MM	DD	YY			
Influenza:	MM	DD	YY											

Medical Provider's Name	Medical Provider's Telephone Number
Signature of Provider	Date MM DD YY

*Please note that some dosages or gaps of time between vaccinations will necessitate additional immunization or boosters to ensure your child is compliant with state requirements. UTP will make every effort to inform families prior to the administering of any additional vaccinations, but we urge families to have the most current immunization records displayed on this document



HEALTH HISTORY & PHYSICAL FORM

Student's Family Name			Student's Given Name(s)		
Date of Birth	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YY"/>	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address					
State/Province			Zip/Postal Code		
Country of Birth			Telephone Number		
Family Doctor/Medical Provider			Telephone Number		
Weight			Blood Pressure		
Height			Hearing		
Pulse			Vision		
Development			<input type="checkbox"/> Normal	<input type="checkbox"/> Delayed	
Physical Exam Within Normal Limits			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has this student ever suffered a concussion?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text" value="Years"/>
This student may participate in			<input type="checkbox"/> All sports and school activities	<input type="checkbox"/>	Sports with the following restrictions
			<input type="checkbox"/> May not participate in sports		
This child has or has had the following: (check all that apply)					
Anemia	<input type="checkbox"/>	Nephritis	<input type="checkbox"/>		
Arthritis	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>		
Chicken Pox	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>		
Fifth Disease	<input type="checkbox"/>	Seizures	<input type="checkbox"/>		
Heart Condition	<input type="checkbox"/>	Surgery	<input type="checkbox"/>		
Mononucleosis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>		
Please list any allergies					
Food: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe					
<input type="text"/>					
Medication: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe					
<input type="text"/>					
Animals: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe					
<input type="text"/>					
Other: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe					
<input type="text"/>					
Comments and Details required for all boxes checked					
Is there anything concerning the health of your child that the school nurse should know in order to meet his/her needs?					
Medical Provider's Name			Medical Provider's Telephone Number		
Signature of Provider			Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YY"/>		



OVER THE COUNTER (COMMON) MEDICATION ADMINISTRATION CONSENT

I request

, my patient, receive the following medication in accordance with the instructions below:

Name of Medication
Diagnosis
Prescribed dosage, frequency, and route of administration
Time to be taken during school hours
Possible side effects (If Any)

I also give consent, and approve nursing staff to give the following common medications at their recommended dosage, as needed (Check All That Apply):

Tylenol	<input type="checkbox"/>	Ibuprofen	<input type="checkbox"/>
Advil	<input type="checkbox"/>	Benadryl	<input type="checkbox"/>
Other	<input type="checkbox"/>		<input type="checkbox"/>

Name of Physician or Licensed Prescriber	
<div>Prescriber Signature</div>	
Physician Address	
State/Province	Zip/Postal Code

<div>Signature of Parent/Guardian</div>

