

SUMMER 2010

CRESTWOOD COUNTRY DAY SCHOOL
SUMMER PROGRAM MEDICAL INFORMATION FORM

NAME AND PHONE OF INSURANCE CO.: \_\_\_\_\_

IDENTIFICATION NO.: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

NAME OF CHILD: \_\_\_\_\_ SEX: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_
(LAST) (FIRST)

ADDRESS: \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_

WORK: \_\_\_\_\_ WORK: \_\_\_\_\_

CELL: \_\_\_\_\_ CELL: \_\_\_\_\_

IN CASE OF ILLNESS OR ACCIDENT, NOTIFY: Nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached:

1) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ OR 2) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_
(NAME) (PHONE #) (NAME) (PHONE #)

ALLERGIES (ASTHMA,SINUSITIS,ETC) OR SPECIAL CONDITIONS PLEASE EXPLAIN:

CHECK ILLNESSES THAT CHILD HAS HAD

- APPENDICITIS DISCHARGING EAR MUMPS SEIZURES
ASTHMA FREQUENT COLDS POLIO TONSILLITIS
CHICKEN POX GERMAN MEASLES RHEUMATIC FEVER TUBERCULOSIS
DIPHThERIA MEASLES SCARLET FEVER WHOOPING cough

OPERATIONS OR RECENT ILLNESS: \_\_\_\_\_

CURRENT PRESCRIBED MEDICATIONS: \_\_\_\_\_

For the benefit of your child, the Directors should be made aware of any treatment for emotional, neurological, physical or psychiatric disorders. Does your child receive any special services in or out of school? If yes, please detail on the back of this form. In addition, any child who presents a risk to themselves or others, may be discharged from Crestwood at the discretion of the Directors. In the event I cannot be reached by phone, I hereby give permission to any local doctor or hospital and Crestwood Country Day School to administer emergency treatment to my child/ren.

I, \_\_\_\_\_ parent/guardian of \_\_\_\_\_, authorize any physician, nurse or other health care provider, to communicate with the medical staff and Directors of Crestwood Country Day School, or his/her designee, about my child's medical condition, treatment and/or prognosis. I/We further authorize the medical staff of Crestwood Country Day School to discuss with the Directors, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

(TO BE FILLED IN BY MEDICAL DOCTOR)

NAME OF CHILD: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ LBS

IMMUNIZATION UPDATE:

- DPT(or DT,) / / CHICKEN POX Chest Xray
DPT(or DT,)Booster HepB / / Lead Screening
MMR / Other Sickle Cell Test
Tetanus Booster / POLIO(TOPV) / / AdditionalProcedures
HIB / / / TB Screening

I have examined the above patient on \_\_\_\_\_. (He) (She) is in good health and may participate in all activities without restrictions, except as noted:

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ PHONE:(\_\_\_\_) \_\_\_\_\_

PHYSICIAN'S PRINTED NAME \_\_\_\_\_ DATE: \_\_\_\_\_