

2020/2021

CRESTWOOD COUNTRY DAY SCHOOL
SCHOOL PROGRAM/DAY CARE MEDICAL INFORMATION FORM

NAME AND PHONE OF INSURANCE CO.:
IDENTIFICATION NO.: HOME PHONE: ( )
NAME OF CHILD: (LAST) (FIRST) SEX: BIRTH DATE:
ADDRESS:

PARENT 1: WORK: CELL:
PARENT 2: WORK: 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/OR DIET, 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 (Please Specify):

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 COMPLETED BY PHYSICIAN,PHYSICIAN ASSISTANT OR NURSE PRACTITIONER))

NAME OF CHILD: HEIGHT: WEIGHT: LBS

IMMUNIZATION UPDATE: (Include all dates)

DPT(or DT,) CHICKEN POX Lead Screening Date (Attach Statement)
DPT(or DT,)Booster HepB
MMR Other
Tetanus Booster POLIO(TOPV)
HIB TB Screening Pos Neg Specify Test
Hearing Vision Dental Type: Tine Mantoux
(Do any of the above require special attention)

I have examined the above patient and on the basis of my findings the child is in good health, (s)he is free from contagious and communicable disease and may participate in all activities and day care without any restrictions, except as noted:

EXAMINERS SIGNATURE: PHONE:( )

EXAMINERS PRINTED NAME DATE:
ADDRESS CITY STATE ZIP