

GRADE 1-6 ONLY

MEDICAL FORM 2008-2009 SCHOOL YEAR

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE STUDENTS STARTS CLASSES

Student's Name _____ Grade _____ Sex _____ Date of Birth _____

During the school year, student lives primarily with: MOM DAD BOTH PARENTS GUARDIAN

LIST ALL PARENTS/GUARDIANS BELOW:

Parent's Name _____ Parent's Name _____

Address _____ Address (if different) _____

City, State _____ City, State _____

Home Phone () _____ Home Phone (if different) () _____

Business Phone () _____ Business Phone () _____

Cell Phone () _____ Cell Phone () _____

Emergency Contact (if parent/guardian cannot be reached)

Name _____ Relationship to student _____ Daytime Phone () _____

Dentist's Name _____ Phone: _____

Please indicate yes or no, and describe where applicable:

Has food allergies Yes No *please list:* _____

Has medication allergies Yes No *please list:* _____

Takes daily medications Yes No *Please List:* _____

Consent for Medication Administration

(Signature required below)

The school nurse is authorized to administer the following over-the-counter meds :

- | | | |
|---------------------------------------|---|----------------------------------|
| <input type="checkbox"/> Advil/Motrin | <input type="checkbox"/> Sudafed | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Aleve | <input type="checkbox"/> Midol | <input type="checkbox"/> Visine |
| <input type="checkbox"/> Antacid | <input type="checkbox"/> Pepto-Bismol | |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Robitussin (expectorant) | |

Any of the above

Signature of Parent/Guardian _____ Date _____

Consent for Medical Treatment

(Signature required below)

I give my permission for the school nurse to administer first-aid if needed. In the event that I cannot be reached and emergency hospital care is needed, I give my permission for my child to be taken to the hospital and given the necessary emergency care.

Signature of Parent/Guardian _____ Date _____

***Student's doctor must complete the reverse side of this form.**

(Individual physician reports documenting physical exam and immunization record may be used, however, student cannot start school unless **MD Consent for Activities and Medication Administration** is signed by physician at the bottom of this page.)

STUDENT NAME: _____

Significant past illness or injury including allergies, surgery and chronic conditions:

Current Medical Problems: _____

IMMUNIZATION RECORD *source: Immunization Guidelines, NYS Education Department

Vaccine	Date	Date	Date	Date	Date	Date
DTaP, DTP						
Polio OPV or IPV						
Measles						
Mumps						
Rubella						
or MMR #1						
MMR # 2						
Hepatitis B						
Varicella						
HIB						
	Date			Result		
PPD test Mantoux						
❖ Lead						

❖ **Required for Pre-K & K only**

Significant Family History _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____ Scoliosis _____
Required by law

Vision Screening: Rt. _____ Lt. _____ Hearing: Rt. _____ Lt. _____

ACTIVITY: Full Limited Please explain: _____

ABNORMAL PHYSICAL FINDINGS OR CONCERNS: _____

MD CONSENT FOR ACTIVITIES AND MEDICATION ADMINISTRATION

I have examined this student and have found his/her physical exam within normal limits. He/she is physically fit to participate in Physical Education classes and/or sports. I give my permission for the school nurse to administer the medications indicated by the parents on the reverse side of this form.

SIGNATURE OF EXAMINING PHYSICIAN _____ DATE OF EXAM: _____

Physician Name (please print or stamp): _____
Address and Telephone number: _____