

Columbia Grammar & Preparatory School, 5 W. 93rd Street, NY, NY 10025

PREP SCHOOL MEDICAL FORM 2008-2009 SCHOOL YEAR
THIS FORM MUST BE COMPLETED AND RETURNED BEFORE SEPTEMBER 1

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: _____

This student: Has food allergies Yes No *please list:* _____

Has medication allergies Yes No *please list:* _____

Please list all daily medications and dosages: _____

PLEASE DO NOT SEND STUDENTS TO SCHOOL WITH MEDICATIONS FROM HOME. CALL THE NURSE'S OFFICE IF HE/SHE NEEDS TO TAKE A PARTICULAR DRUG DURING THE SCHOOL DAY.

Consent for Medication Administration (Signature required below)	Consent for Medical Treatment (Signature required below)												
<p>The school nurse is authorized to administer the following over-the-counter meds (please ✓):</p> <table border="0"><tr><td><input type="checkbox"/> Advil/Motrin</td><td><input type="checkbox"/> Chor-trimeton</td><td><input type="checkbox"/> Sudafed</td></tr><tr><td><input type="checkbox"/> Aleve</td><td><input type="checkbox"/> Midol</td><td><input type="checkbox"/> Tylenol</td></tr><tr><td><input type="checkbox"/> Antacid</td><td><input type="checkbox"/> Pepto-Bismol</td><td><input type="checkbox"/> Visine</td></tr><tr><td><input type="checkbox"/> Benedryl</td><td><input type="checkbox"/> Robitussin (expectorant)</td><td></td></tr></table> <p><input type="checkbox"/> any of the above</p> <p>Signature of Parent/Guardian _____ Date _____</p>	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Chor-trimeton	<input type="checkbox"/> Sudafed	<input type="checkbox"/> Aleve	<input type="checkbox"/> Midol	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Antacid	<input type="checkbox"/> Pepto-Bismol	<input type="checkbox"/> Visine	<input type="checkbox"/> Benedryl	<input type="checkbox"/> Robitussin (expectorant)		<p>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.</p> <p>Signature of Parent/Guardian _____ Date _____</p>
<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Chor-trimeton	<input type="checkbox"/> Sudafed											
<input type="checkbox"/> Aleve	<input type="checkbox"/> Midol	<input type="checkbox"/> Tylenol											
<input type="checkbox"/> Antacid	<input type="checkbox"/> Pepto-Bismol	<input type="checkbox"/> Visine											
<input type="checkbox"/> Benedryl	<input type="checkbox"/> Robitussin (expectorant)												

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

THIS PAGE MUST BE COMPLETED BY STUDENT'S PHYSICIAN

(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	Requirement (grades 7-12) *	Date	Date	Date	Date	Date	Date
DTaP, DTP	3 or more doses						
Tdap	1 dose (6 th & 7 th graders born after 1/1/94)						
Polio OPV or IPV	3 doses						
Measles	2 doses or serology						
Mumps	1 dose or serology						
Rubella	1 dose or serology						
or MMR #1							
MMR # 2							
Hepatitis B	2 or 3 dose series or serology						
Varicella	At least 1 dose						
		Date		Result			
PPD test Mantoux	For all students new to NYC secondary schools						

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: _____