Medical and Emergency Form for 2018-2019

Student Name:_____ Sex:_____ Date of Birth:_____

Age (on first day of school):_____

	Primary parent or guardian to contact during school day:	Second Parent:
Name		
Home address		(if different)
Home phone		
Cell phone		
Work phone		
Work place, address		

Please place an asterisk next to "first call" phone number for us to use!

In case of an emergency notify (if parent is not available):_____
Phone:_____

Current medication(s) (send instructions and original container with prescription label): _____

_____

Any other health issues: _____

Name of dentist/orthodontist:_____ Phone:_____

Name of child's physician:_____ Phone:_____

Insurance carrier:_____ Policy/Group #:_____

Hospital Preference:_____

Additional health related information:_____

Any allergies (food, drug, plant, insect, etc):_____

Does your child have any limitations that we should be aware of?_____

Permission is granted to the Levey Day School, its staff and volunteers, to arrange transport for ambulance for my child _____ to the closest hospital or facility so equipped to care for him/her in an emergency situation. I understand that I will be contacted immediately and informed of any such action.

Parent/Guardian signature: _____Date: _____

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Student Immunization

According to state law, students who do not have a record of immunizations at the time of registration are allowed 90 days to present one. This requirement can only be waived if properly signed medical, religious, or personal objection is filed with the school.

Immunization History

	1st dose Mo/day/yr	2nd dose Mo/day/yr	3rd dose Mo/day/yr	4th dose Mo/day/yr	5th dose Mo/day/yr
Varicella Vaccine					
Varicella disease (date)					
Tetanus/Diphtheria & Pertussis with DTaP					
MMR (Measles, Mumps, Rubella)					
Polio					
HIB					
Hep B					
Other					

To be signed by Licensed Physician

I have examined this child within the past two years. Date examined:_____.
In my opinion, the child's condition _____does _____does not preclude his/her participation in school activities.

Height:_____ Weight:_____

This child is under the care of a physician for the following condition(s): _____

_____

Current treatment (include current medication):_____
Explanation of any reported loss of consciousness, convulsions or concussion (seizure disorder):_____

Does this child have asthma? _____yes _____no Does this child have diabetes? _____yes _____no

Does this child have allergies? _____yes _____no If yes, please describe:_____

_____

Does this child have any other conditions the school should know about? _____

Licensed Physician's signature: _____ Date: _____

Address: _____Phone_____

Form completed by: _____ Date: _____

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