



## Levey Day School Medical Form 2011/2012

Student Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age (on first day of school): \_\_\_\_\_

	<b>Primary parent or guardian to contact during school day:</b>	<b>Second Parent:</b>
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) \_\_\_\_\_

Health problems we should know about: \_\_\_\_\_

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): \_\_\_\_\_

Activities to be encouraged or limited: \_\_\_\_\_

Permission is granted to the Levey Day School, its staff and volunteers, to transport 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

	1 <sup>st</sup> dose Mo/day/yr	2 <sup>nd</sup> dose Mo/day/yr	3 <sup>rd</sup> dose Mo/day/yr	4 <sup>th</sup> dose Mo/day/yr	5 <sup>th</sup> 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

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: \_\_\_\_\_