PARENT HEALTH FORM

Child's Name		Gender	Birthdate:
Father		Address	
Father Home Phone	Father Work Phone		Father Cell Phone
Mother (Maiden Name)		Mother Present Name	
Address			
Mother Home Phone	Mother Work Phone		Mother Cell Phone
Physician	Phone		Physician Address

PLEASE LIST ANY ON-GOING MEDICAL PROBLEMS YOUR CHILD HAS: ____

____

ILLNESS & CONDITIONS THE CHILD HAS HAD OR HAS PRESENTLY (GIVE DETAILS)

Anemia	Heart Disease	Rheumatic Fever
Chicken Pox	Ear Infections	Frequent Colds
German Measles (Rubella)	Speech Problems	Frequent Sore Throat
Measles	Swallowing Problems	Eye Problems
Scarlet Fever	Asthma	Seizures
Mumps	Diabetes	Wears Glasses
Pneumonia	Contact w/ Tuberculosis	Other:

SERIOUS ACCIDENTS, OPERATIONS, OTHER ILLNESSES, X-RAYS, HANDICAP, ETC. (Give details): ______________________

____

MEDICATIONS YOUR CHILD TAKES ON A DAILY BASIS: ____

IN THE EVENT THAT A PARENT/GUARDIAN CANNOT BE REACHED, PLEASE LIST TWO PEOPLE WHO COULD BE CALLED TO PICK UP YOUR CHILD IN CASE OF ILLNESS OR EMERGENCY:

NAME: _____________________________ **RELATIONSHIP TO STUDENT:** _______________**PHONE NUMBER:**___________

NAME: _____________________________ **RELATIONSHIP TO STUDENT:** _______________**PHONE NUMBER:**___________

IN CASE OF EMERGENCY, I GIVE PERMISSION TO CALL THE DOCTOR OR DENTIST LISTED BELOW:

PHYSICIAN: ____ **PHONE NUMBER:** _________________________

DENTIST: ____ **PHONE NUMBER:** _________________________

HOSPITAL PREFERENCE: ____

PARENT/GUARDIAN SIGNATURE: ____ **DATE:** _________________

Physician's Health Form on Back ➡

Fax # (518) 370-1514

PHYSICIAN'S HEALTH FORM

A physical exam is required for all new entrants and those entering Nursery, Pre-K, Kindergarten, 2nd, 4th, 7th & 10th grade. In addition, all Upper School students participating in sports must have a physical within the past year. Please have your physician complete this form and return to school. Brown School fax # 370-1514

NAME: ____Gender: _________ BIRTHDATE: _____________________

GRADE: _______________ HEIGHT: ___________ WEIGHT: ___________ BMI: ____________ PERCENTILE: __________

EYES: R ______________ L _______________ WITH GLASSES: R ______________ L ______________

EARS: HEARING LOSS: _______________________ OTHER DEFECT: ___________________________________

NUTRITION: _________________________________ TEETH: (Temporary): _______________________________

GUMS: ______________________________________ (Permanent): _______________________________

TONSILS: ____________________________________ NOSE: ______________________________________

GLANDS: __________________________ THYROID: _________________________ OTHER: _______________________

ASTHMA: ________________________ ALLERGIES: ____

HEART: ____________________ BLOOD PRESSURE: ______________ LUNGS: _____________ CHEST X-RAY: _________

ORTHOPEDIC STRUCTURAL: __________________________ SCOLIOSIS: ____________________ FEET: ______________

SKIN:______________ HERNIA: _____________ GENITOURINARY: _____________TANNER STAGE: _________________

SPEECH: _____________________ EPILEPSY: _______________________ NERVOUS SYSTEM: _____________________

IMMUNIZATIONS-PROVIDE COMPLETE DATES:

POLIO: 1 ___________ 11____________ 111 _____________ BOOSTERS: _______________ ________________

DPT: 1 __________ 11__________ 111 __________ BOOSTERS: ____________ ____________ Tdap: ____________

MMR: 1 __________ 11 __________ OR MEASLES: _____________ MUMPS: ____________ RUBELLA: _____________

Hib: 1 _________ 11________ 111 _________ PNEUMOCCOCAL CV: 1________ 11_________111_______ 1V ________

HEPATITIS B: 1 _________ 11 _________ 111 __________ VARICELLA (CHICKEN POX): _______________

TB TESTING DATE: ______________________ RESULT: _______________________

LEAD SCREENING: ____

SPECIAL DIETARY NEEDS: ____

FOOD ALLERGIES: ____ REACTION: _______________________________

MEDICATION ALLERGIES: _____________________________________ REACTION: _______________________________

OTHER ALLERGIES: ____ REACTION: _______________________________

CLASSIFICATION FOR PHYSICAL EDUCATION/SPORTS: ____

MEDICATIONS: ____

RESTRICTIONS, LIMITATIONS OR SPECIAL MEDICAL TREATMENTS: ____

____

PHYSICIAN: ____ DATE OF EXAM: _______________________

PRINT NAME: ____