

SUMMER 2008

CRESTWOOD COUNTRY DAY SCHOOL
SUMMER PROGRAM MEDICAL INFORMATION FORM

NAME AND PHONE OF INSURANCE CO.: _____

IDENTIFICATION NO.: _____ HOME PHONE: (____) _____

NAME OF CHILD: _____ SEX: _____ BIRTH DATE: _____
(LAST) (FIRST)

ADDRESS: _____

MOTHER'S NAME _____ FATHER'S NAME _____

WORK: _____ WORK: _____

CELL: _____ CELL: _____

IN CASE OF ILLNESS OR ACCIDENT, NOTIFY: Nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached:

1) _____ (____) _____ OR 2) _____ (____) _____
(NAME) (PHONE #) (NAME) (PHONE #)

ALLERGIES (ASTHMA,SINUSITIS,ETC) OR SPECIAL CONDITIONS PLEASE EXPLAIN:

CHECK ILLNESSES THAT CHILD HAS HAD

- APPENDICITIS DISCHARGING EAR MUMPS SEIZURES
ASTHMA FREQUENT COLDS POLIO TONSILLITIS
CHICKEN POX GERMAN MEASLES RHEUMATIC FEVER TUBERCULOSIS
DIPHThERIA MEASLES SCARLET FEVER WHOOPING cough

OPERATIONS OR RECENT ILLNESS: _____

CURRENT PRESCRIBED MEDICATIONS: _____

For the benefit of your child, the Directors should be made aware of any treatment for emotional, neurological, physical or psychiatric disorders. Does your child receive any special services in or out of school? If yes, please detail on the back of this form. In addition, any child who presents a risk to themselves or others, may be discharged from Crestwood at the discretion of the Directors. In the event I cannot be reached by phone, I hereby give permission to any local doctor or hospital and Crestwood Country Day School to administer emergency treatment to my child/ren.

I, _____ parent/guardian of _____, authorize any physician, nurse or other health care provider, to communicate with the medical staff and Directors of Crestwood Country Day School, or his/her designee, about my child's medical condition, treatment and/or prognosis. I/We further authorize the medical staff of Crestwood Country Day School to discuss with the Directors, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

Parent Signature _____ Date _____

(TO BE FILLED IN BY MEDICAL DOCTOR)

NAME OF CHILD: _____ HEIGHT: _____ WEIGHT: _____ LBS

IMMUNIZATION UPDATE:

- DPT(or DT,) / / CHICKEN POX Chest Xray
DPT(or DT,)Booster HepB / / Lead Screening
MMR / Other Sickle Cell Test
Tetanus Booster / POLIO(TOPV) / / AdditionalProcedures
HIB / / / TB Screening

I have examined the above patient on _____. (He) (She) is in good health and may participate in all activities without restrictions, except as noted:

PHYSICIAN'S SIGNATURE: _____ PHONE:(____) _____

PHYSICIAN'S PRINTED NAME _____ DATE: _____