

CRESTWOOD COUNTRY DAY SCHOOL

MEDICAL RECORD

PARENT AND CHILD PROGRAM--PARENT INFORMATION:

Name: _____
Last First Initial Sex Birthdate

ADDRESS: _____ PHONE: _____

In case of emergency, notify:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Height: _____ Weight: _____

HEALTH HISTORY (Check those that apply)

| | | |
|-----------------------------------|----------------------|-------------------|
| Frequent Ear Infection _____ | Tuberculosis _____ | Hay Fever _____ |
| Convulsions _____ | Mononucleosis _____ | Asthma _____ |
| Diabetes _____ | Asthma _____ | Allergies to: |
| Bleeding/Clotting Disorders _____ | Polio _____ | Medications _____ |
| Hypertension _____ | Chicken Pox _____ | Foods _____ |
| Epilepsy _____ | German Measles _____ | Other _____ |
| | Measles _____ | |

Operations: _____

Recent Illness: _____

Disability or chronic/ recurring illness: _____

Any specific activities to be limited by physicians advice: _____

Dietary modifications: _____

Current Medications: _____

Other diseases or details of above: _____

Name of Dentist: _____

Name of Physician: _____

Date of last physical examination: _____

Do you carry medical/hospital insurance? _____ If so, indicate:

Carrier: _____ Policy or Group #: _____

This health history is correct to the best of my knowledge and I have been medically approved this year to perform the duties required. I hereby give permission to the physician/medical staff selected by the program director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and surgery for me in the event the emergency contacts cannot be reached.

SIGNATURE: _____ DATE: _____