2024/2025

CRESTWOOD COUNTRY DAY SCHOOL
SCHOOL PROGRAM/DAY CARE MEDICAL INFORMATION FORM

NAME AND PHONE OF INSURANCE CO.: ____
IDENTIFICATION NO.: ________________________________HOME PHONE: (___)______________________________
NAME OF CHILD: ____ SEX: ______ BIRTH DATE: __________
(LAST) (FIRST)
ADDRESS: ____

PARENT 1:________________________ PARENT 2:___________________________
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/OR DIET, 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 (Please Specify):____

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 COMPLETED BY PHYSICIAN,PHYSICIAN ASSISTANT OR NURSE PRACTITIONER))

NAME OF CHILD: ____ HEIGHT: __________ WEIGHT: _________LBS
IMMUNIZATION UPDATE: (Include all dates)

DPT(or DT,)_____/______/______/______	CHICKEN POX______________	Lead Screening Date______________(Attach Statement)
DPT(or DT,)Booster____________	HepB____/________/__________	
MMR__________/_____________	Other________________________	
Tetanus Booster________/_______	POLIO(TOPV)_____ /______/___	
HIB_____/______/_____/_______	TB Screening Pos__ Neg.___ Specify Test	
Hearing_______ Vision_______Dental_____	Type: Tine___Mantoux__	
(Do any of the above require special attention)		

I have examined the above patient and on the basis of my findings the child is in good health, (s)he is free from contagious and communicable disease and may participate in all activities and day care without any restrictions, except as noted:
____
____

EXAMINERS SIGNATURE: ____ PHONE:(___)________________________

EXAMINERS PRINTED NAME____ DATE:___________________________
ADDRESS________________________________CITY______________________STATE_________ZIP________________________