

The Clearpool Education Center

Over 100 Years of Learning Beyond the Classroom

33 Clearpool Rd • Carmel, NY 10512 • Phone: (845) 225-8226 • Fax: (845) 225-6337

Health History Form

Please Print Child's Full Name:

Date of Birth _____

Age _____

Height _____ Weight _____

Male/Female (circle one)

Group attending Clearpool with (school, organization): Brooklyn Friends School

Grade _____

Emergency Contact Information

Parent/Guardian Name _____

Home Address _____

Phone (h) _____ (w) _____ (c) _____

Physician/Clinic Name _____

Telephone _____

Health Insurance Name _____

Address _____

Insurance Number _____

Second Emergency Contact

Name _____

Relationship to child _____

Home Address _____

Phone _____ (h) _____ (w) _____ (c) _____

Health History

Does your child have any problems with the following: Circle yes or no?

Asthma	yes	no	Environ. Allergies	yes	no
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Seizures	yes	no	Allergy to Insect Bites	yes	no
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Diabetes	yes	no	Hearing Loss	yes	no
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Heart problems	yes	no	Strenuous Exercise	yes	no
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Sleepwalking	yes	no	High Blood Pressure	yes	no
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Bed wetting	yes	no			
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If yes please explain.

Does your child have any other serious medical problems or been under a physicians care

Recently? If yes explain _____

Does your child have any allergies (food, medications)? **If yes, please make sure you have an allergy action plan on file with the BFS School Nurse!** _____

Diet restrictions? _____

Activity Restrictions: Is child **restricted** from participating in any of the following activities?

Swimming yes no

Diving yes no

Athletic Activities yes no

Recreation yes no

Additional comments regarding restrictions:

Has your child received all required immunizations? Yes No

What was the date of your child's last TETANUS shot? _____

Immunizations (please include dates); you may attach this year's immunization record.

DT, DPT _____ Measles #1 _____ Measles #2 _____

Polio _____ Hep B #1 _____ Hep B #2 _____

Hep B #3 _____ MMR _____ Varicella _____

HIB _____ Other _____

Medications--Signatures required below!

Clearpool offers some limited Over the Counter (OTC) medications for visiting students on an as needed basis, provided the parent checks the medications desired and the student's doctor and parent sign this form. This permission to give OTC medication is specific to Clearpool and is not shared with the student's original school.

Without signatures of the doctor and parent there will be no medication administered by the Clearpool nurse--not even Tylenol for a fever.

If your child needs to take prescription medications, please have your doctor fill out and sign the *Authorization for Medication Administration*, and submit the medication to MaryEllen Ostrander, the school nurse. All medications must be submitted in their original pharmacy container and must be held by a school representative or the nurse. No homeopathic medications or vitamins may be submitted.

The student may not have any medications (pill or oral liquid) in his/her possession. This includes over-the-counter medications like Tylenol. Only the Clearpool nurse will administer medications according to the written instructions provided by the doctor and co-signed by the parent. Some students needing Epi-Pens or asthma inhalers may meet the requirements for self-administration. To find out more about this, please contact MaryEllen at ext 241, or visit our website: <http://www.brooklynfriends.org/studenthealth>.

If your child has **allergies or asthma**, the MaryEllen will copy and include your child's action plans and self medication release forms that were submitted in the fall. If you are unsure if these plans have expired please contact Mary Ellen at 718-852-1029 ext 241 or mostrander@brooklynfriends.org. These plans are good for one year unless there have been changes to them.

Over the counter medications:

My child may have the following medication if needed: Physician's co-signature needed!

Tylenol _____
Cough Medicine _____
Antacid _____
Benadryl _____

Parent/ Guardian Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Physician's seal: