

BROOKLYN FRIENDS SCHOOL

2011-12 Confidential Student Health Form

375 Pearl Street, Brooklyn, NY 11201

T 718-852-1029 x 241

F 718-643-4868

www.brooklynfriends.org

The School will act based on the information you provide. It is expected that this form is accurate, complete, and up-to-date. Note that **X** indicates a signature is required. **Part I & Part II must be completed.** Students diagnosed with **Asthma** and/or **Allergies** must complete Action Plan forms and **attach to this document.** Students requiring medication to be dispensed at school must complete Prescription Medication Form and/or Self-Medication Form and **attach to this document.**

Part I: To be completed/signed by parent/guardian - Due Aug. 15

Student Name _____ Gender _____ Date of Birth ___/___/___
LAST FIRST MIDDLE mo. day year

Address _____ Grade in Sept '11: _____

Parent/Guardian Name _____

E-mail _____

Parent/Guardian Name _____

E-mail _____

Parent/Guardian Phone Numbers:	
Home	_____
Cell	_____
Work	_____
Parent/Guardian Phone Numbers:	
Home	_____
Cell	_____
Work	_____

Emergency Contact in the event BFS is unable to reach parent(s):

Name: _____ Phone: _____ Relationship: _____

EMERGENCY CARE AUTHORIZATION: I give my permission for the school to administer first aid to my child as needed. I give permission for the school to contact my child's physician for medical instructions. In the event that I cannot be reached and emergency hospital care/treatment is needed, I give my permission for my child to be taken to the nearest hospital and given the necessary care.

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

Health Insurance Information: _____

CONSENT TO SHARE INFORMATION: I give my permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

PERMISSION TO ADMINISTER NON-PRESCRIPTION (OVER THE COUNTER OTC) MEDICATION TO STUDENT SIGNATURES REQUIRED

Authorization is given to the School Nurse to administer OTC medications I have checked below. I understand that medication will be administered based on the child's weight. Authorization must be counter-signed by child's physician, or this is not valid.

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen (Tylenol) – 325mg tablets | <input type="checkbox"/> Ibuprofen (Motrin, Advil) – 200mg tablets |
| <input type="checkbox"/> Acetaminophen Chewable Tablets, 80mg | <input type="checkbox"/> Ibuprofen Liquid (Motrin, Advil) 100mg/5ml |
| <input type="checkbox"/> Acetaminophen Liquid 80mg/5ml | <input type="checkbox"/> Tums |
| <input type="checkbox"/> Benadryl capsules (2.5mg) <i>not for seasonal allergies</i> | <input type="checkbox"/> Hydrocortisone 1% topical cream |
| <input type="checkbox"/> Benadryl Liquid 12.5mg/5ml <i>not for seasonal allergies</i> | <input type="checkbox"/> First Aid burn gel topical gel |
| <input type="checkbox"/> Cepacol Lozenges | <input type="checkbox"/> Sun block/lotion |

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

X PHYSICIAN SIGNATURE _____ DATE _____

Please note: this form is used by Brooklyn Friends afterschool and summer programs, as applicable.

**All Health Forms and School Health Policies are on the BFS Website: <http://www.brooklynfriends.org/healthforms>
Attach a recent photo of your child to this form. Make a copy of all forms for yourself. Hand-deliver or mail by Aug. 15th to BFS, 375 Pearl Street, Brooklyn, NY 11201, Att: School Nurse**

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Part II: To be completed/signed by physician/health care provider - Due Aug. 15

Student Name LAST FIRST MIDDLE Date of Birth mo. / day / year

Date of Physical Exam: Grade in Sept '11:

Height: Weight: Body Mass Index: Blood Pressure:

General Appearance:

Table with 6 columns: HEENT, Dental, Neck, Lymph Nodes, Lungs, Cardiovascular, Abdomen, Genitourinary, Extremities, Skin, Neurological, Back/spine, Psychosocial, Language, Behavioral. Each cell contains 'NI' or 'Abnl' and a checkbox.

Describe abnormalities:

Physical Maturity: (Tanner Stage): I. II. III. IV. V.

Does the student have a past or present medical history of the following:

- Asthma* Severity: Intermittent Mild Persistent Moderate Persistent Severe Persistent
Attention Deficit Hyperactivity Disorder Life-Threatening Allergy *
Chronic or recurrent otitis media Orthopedic injury/disability
Congenital or acquired heart disorder Seizure disorder
Developmental/learning problem Speech, hearing, or visual impairment
Diabetes * Tuberculosis (latent infection or disease)
OTHER (specify) Please explain all checked items on an addendum

Please list the student's allergies * (Food, Drug, Environmental) on the line below:

* Action Plan and/or Medication Administration Form Required. Download form from BFS website, complete and attach.

Dietary Restrictions: None Yes (list):

Screenings: Vision: R Corrected Uncorrected Hearing: Normal Abnormal
L Corrected Uncorrected Scoliosis: Negative Positive

Lead: (0-10) PPD/Mantoux Date Placed Date Read Neg Pos

IMMUNIZATIONS - List dates or provide separate sheet

- Hep B
Rotavirus
DTP/DTaP/DT
Hib
PCV
Polio
Influenza
MMR
Varicella
Td
Tdap
Hep A
Meningococcal
HPV
Other

PHYSICIAN CLEARANCE/ SIGNATURE REQUIRED

This student may participate fully in school physical activities. OTC medications as indicated by parent in Part I may be administered as per package protocol.

This student has the following physical restrictions:

Provider's Name: Provider's stamp:
Address:
Phone:
Fax:
Signature: