The WALDORF SCHOOL of GARDEN CITY

NAME: ____________________ GRADE 2018-2019__________

225 Cambridge Avenue, Garden City, New York 11530
Tel: (516) 742-3434 / www.waldorfgarden.org

MEDICAL FORM (side 1)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Name: ______________________________ Birth Date: ______________ Gender: ______________

Home Phone: ____

Parent/Guardian 1: ______________________________ Day Phone: ____________ Cell Phone: ______________

Parent/Guardian 2: ______________________________ Day Phone: ____________ Cell Phone: ______________

Authorized Emergency Contact: ____________________ Day Phone: ____________ Cell Phone: ______________

Name of Student's Doctor: ____

Doctor's Address: ____

Doctor's Telephone: ______________________________ Fax #: ______________________________

Health Insurance: ____

I, ______________________________________, am the parent/legal guardian of ___________________________________,
who was born on ______________________ and who resides at ____.
I authorize a faculty member of The Waldorf School of Garden City to consent to any emergency treatment which may be necessary for my child named above in case of illness or injury after efforts to contact me are unsuccessful. Such treatment may include, but is not limited to, examination, x-rays, laboratory tests, medical and surgical treatment, use of medication, anesthesia and/or sutures as well as admission for hospital care as may be required. I understand that such care will be based upon medical advice.

_____________ day of _______________, 20______ ______________________________________

Signature of Parent or Legal Guardian

STUDENT'S HEALTH HISTORY: MUST BE COMPLETELY FILLED OUT BY PARENT / GUARDIAN

Please check YES or NO to the following questions. If you answer yes to any questions explain below.

Question	YES	NO
1. Does the student have allergies? *List:* ______________________________	❑	❑
2. Does the student take any daily medications? *List:* ______________________________	❑	❑
3. Does the student have any ongoing medical conditions (i.e. seizures, diabetes, asthma, ADHD)? *List:* ______________________________	❑	❑
4. Does the student cough, wheeze or have difficulty breathing DURING or IMMEDIATELY AFTER exercise? *List:* ______________________________	❑	❑
5. Has the student ever had surgery or been hospitalized overnight? *If YES, explain:* ______________________________	❑	❑
6. Has the student ever passed out or nearly passed out DURING exercise? *If yes, explain:* ______________________________	❑	❑
7. Has the student ever had pain/discomfort or pressure in chest DURING exercise? *If YES, explain:* ______________________________	❑	❑
8. Has a doctor ever said the student has a heart murmur, heart problem, high blood pressure, high cholesterol or a heart infection? *List:* ______________________________	❑	❑
9. Has any family member or relative died of a heart problem, heart attach, stroke or a sudden unexplained death before the age of 50? *If YES, explain:* ______________________________	❑	❑
10. Has a doctor ever ordered a test for the student's heart (i.e. echo, stress test)? *Type of Test:* ____________ *When:* ____________	❑	❑
11. Does anyone in the student's family have Marfan's syndrome, hypertrophic cardiomyopathy, long QT syndrome, or other cardiomyopathy? *If YES, explain:* ______________________________	❑	❑
12. Was the student born without or is missing a kidney, eye, testicle or any other organ? *List:* ______________________________	❑	❑
13. Has the student ever had a concussion or serious head injury? *If yes, explain:* ______________________________	❑	❑
14. Has the student ever been hit in the head and been confused, lost memory after the injury or been unable to move arms or legs or felt weak? *If yes, explain:* ______________________________	❑	❑

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Signature of Parent or Legal Guardian

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MEDICAL FORM (side 2)

TO BE COMPLETELY FILLED OUT BY HEALTH CARE PROVIDER

Child's Name: ______________________ **Birth Date:** __________ **Gender:** _______

Date of Exam: ____________________ Height ____________ Weight ________

Body Mass Index: _____ _____ . _____ Blood Pressure ______ Pulse ________

Do you approve this student for ALL interscholastic sports?
❑ YES ❑ NO
Reason for Disqualification:
____
____

Weight Status Category (BMI percentile):

❑Less than 5th ❑6th thru 49th ❑50th thru 84th ❑85th thru 95th ❑96th thru 98th ❑99th & higher

Scoliosis: ____ Lungs: ____

Skin: ____ Abdomen: ____

EENT: ____ Genitalia (Tanner Stage): _______________ /LNMP: _________

Neck / Thyroid: ________________________________ Orthorpedic: Structual Defect: ___________________________

Cardiovascular: ________________________________ Nervous system: ___________________________________

VISION: Right: ______________________ Left: ______________________ Amblyopia: ___________________________

Glasses? ❑ Yes ❑ No Contact Lenses? ❑ Yes ❑ No

Audiogram: Right: ______________________ Left:: ______________________ Tympanogram: _________________________

Past and current medical or psychiatric diagnoses: ____

Past surgical history: ____

Allergies: ____

Medications for routine or emergency use: ____

Past and/or current learning or behavioral problems: ____

Is patient in counseling or therapy? ____

IMMUNIZATIONS

Proof of IMMUNIZATIONS must be any 1 of these 3 items: Immunization certificate signed by MD, Immunization Registry Report (NYSIIS or CIR) from MD or County Health Dept., OR A blood titer or note from MD stating student had the disease.

Dtap 1 ___________ 2) ____________ 3) ___________ 4) ____________ 5) ____________ Tdap __________

Polio (IPV/OPV) 1) ____________2) ____________3) ___________4)_____________

MMR 1) __________ 2) __________ or Mumps __________ Rubella _________ Measles_______

Varicella 1) _________ 2) ________ Hx of disease_________ Antibody_________

Hep B 1) ______________ 2) ______________3) _____________ 4) ______________

HIB 1) ____________ 2) _____________ 3) _____________ 4) _____________ Lead____________

PCV 1) ____________2) ____________3) ______________ 4)_____________5)_____________

Meningitis 1) ___________ 2) ______________ HPV 1) ____________ 2) _____________ 3) _____________

Physician's signature: ____ **Date:** ________________

Physician's stamp: