Summer at the WALDORF SCHOOL of GARDEN CITY

NAME: _____ GRADE 2024-2025_____

225 Cambridge Avenue, Garden City, New York 11530
Tel: (516) 742-3434 ext. 327 / www.waldorfgarden.org

MEDICAL FORM (side 1)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Name: _____ Birth Date: _____ Male: ☐ Female: ☐

Home Phone: _____

Father's Name: _____ Day Phone: _____ Cell Phone: _____

Mother's Name: _____ Day Phone: _____ Cell Phone: _____

Neighbor's Name: _____ 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 authoroze 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 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.

	YES	NO
1a. Do you have allergies? *List:* _____	☐	☐
2. Do you take any daily medications? *List:* _____	☐	☐
3. Do you have any ongoing medical conditions (i.e. seizures, diabetes, asthma, ADHD)? *List:* _____	☐	☐
4. Do you cough, wheeze or have difficulty breathing DURING or IMMEDIATELY AFTER exercise? *List:* _____	☐	☐
5. Have you ever had surgery or been hospitalized overnight? *If YES, explain:* _____	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise? *If yes, explain:* _____	☐	☐
7. Have you ever had pain/discomfort or pressure in your chest DURING exercise? *If YES, explain:* _____	☐	☐
8. Has a doctor ever told you that you have 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 your heart (i.e. echo, stress test)? *Type of Test:* _____ *When:* _____	☐	☐
11. Does anyone in your family have Marfan's syndrome, hypertrophic cardiomyopathy, long QT syndrome, or other cardiomyopathy? *If YES, explain:* _____	☐	☐
12. Were you born without or are you missing a kidney, eye, testicle or any other organ? *List:* _____	☐	☐
13. Have you ever had a concussion or serious head injury? *If yes, explain:* _____	☐	☐
14. Have ever been hit in the head and been confused, lost you memory after the injury or been unable to move your arms or legs or felt weak? *If yes, explain:* _____	☐	☐

_____

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 _____

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 / Throid: _____ 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: