THE BROWNING SCHOOL

52 East 62nd Street New York, New York 10065 212 838 6280 212 355 5602 FAX www.browning.edu

STUDENT HEALTH FORM
2017 - 2018

STUDENT NAME: _____

GRADE: _____ **DATE OF BIRTH:** _____

PARENT/GUARDIAN 1: _____ **PARENT/GUARDIAN 2:** _____

HOME ADDRESS: _____ **HOME ADDRESS:** _____

_____ _____

PHONE: _____ **PHONE:** _____

WORK ADDRESS: _____ **WORK ADDRESS:** _____

_____ _____

PHONE: _____ **PHONE:** _____

PERSONS TO CONTACT IF UNABLE TO REACH PARENTS:

NAME: _____ **NAME:** _____

PHONE: _____ **PHONE:** _____

I give my permission for the School Nurse to administer first aid if such is needed. In the event that I cannot be reached, and emergency/hospital care/treatment is needed, I give permission for my child to be taken to the nearest hospital and given the necessary emergency care.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

The School Nurse may administer the following medications:

____Tylenol _____Ibuprofen _____Benadryl _____Antacid _____Robitussin ____Claritin

Other* (name and dosage): _____

Asthma Medication*: _____ Peak Flow: _____

**Please be advised that any prescription medication must be in a labeled medication bottle from the pharmacy and kept in the Nurse's office. Any maintenance medication must be accompanied by a doctor's order.*

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICAL

To be completed each year

HEIGHT: _____ WEIGHT: _____ BMI: _____

BLOOD PRESSURE: _____ PULSE: _____

VISION (RIGHT): _____ VISION (LEFT): _____

HEARING (TYPE OF TEST): _____

HEARING (RIGHT): _____ HEARING (LEFT): _____

ENT: _____

CARDIOVASCULAR: _____

URINALYSIS: _____

ABDOMEN: _____

HEMOGLOBIN/HEMATOCRIT: _____

GENITALIA: _____

EXTREMITIES: _____

MUSCULO-SKELETAL: _____

SCOLIOSIS CHECK: _____

SKIN: _____

NEUROLOGICAL: _____

EMOTIONAL: _____

DENTAL: _____

NUTRITIONAL: _____

PAST ILLNESSES, INCLUDING CONTAGIOUS DISEASES: _____

_____

OPERATIONS: _____

_____

SIGNIFICANT FAMILY HISTORY: _____

_____

SIGNIFICANT CHRONIC PROBLEMS: _____

_____

MAINTENANCE MEDICATION: _____

_____

IMMUNIZATIONS DURING THE PAST YEAR: _____

_____

ALLERGIES: _____

_____

MAY THE STUDENT PARTICIPATE IN ALL PHYSICAL ACTIVITIES? _____

PHYSICIAN'S SIGNATURE: _____

DATE: _____

PHYSICIAN'S STAMP: _____

TELEPHONE: _____

Student's Name _____ Date of Birth _____

Student's Grade _____ _____

Please include DAY, MONTH and YEAR of each immunization record

IMMUNIZATION HISTORY

	1ST	2nd	3RD	4TH	5TH
DTP					
DT/DTaP					
Tdap					
Hib					
OPV/IPV					
Hep B					
MMR					
VARICELLA					
MANTOUX					
MENINGOCOCCAL MENINGITIS					

PHYSICIAN'S SIGNATURE_____DATE_____

PHSYICIAN'S STAMP_____TELEPHONE_____