THE BROWNING SCHOOL

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

HEALTH FORM

SEPTEMBER 2016 - 2017

Grade________________

STUDENT'S NAME__________________________ BIRTH DATE___________

PARENT'S NAME __________________________

HOME ADDRESS _____________________ TEL. NO.______________

BUSINESS __________________________ TEL. NO______________

CELL NO._____________

PARENT'S NAME ___________________________

HOME ADDRESS _____________________ TEL. NO._____________

BUSINESS __________________________ TEL. NO._____________

CELL NO.____________

PERSONS TO CONTACT IF UNABLE TO REACH PARENTS

____ TEL. NO._____________

_________________________ _____________ TEL. NO.______________

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.

SIGNATURE OF PARENT/GUARDIAN_______________________________________
DATE______________

The school nurse may administer the following medications:

___Tylenol ___Advil ___Sudafed ___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.

SIGNATURE OF PARENT/GUARDIAN _____________________DATE___________

PHYSICAL (To Be Completed each year**)

HEIGHT_______ WEIGHT______BMI__________

BLOOD PRESSURE_________ PULSE________

VISION: RIGHT: ___________ LEFT: _________

HEARING: TYPE OF TEST: __________________

RIGHT: ______________ LEFT: ____________

ENT: ___________________________________

CARDIOVASCULAR________________________

URINALYSIS_____________

ABDOMEN: ______________________________

HEMOGLOBIN / HEMATOCRIT___

GENITALIA: _____________________________

EXTREMITIES: ____________________________

MUSCULO-SKELETAL______________________

SCOLIOSIS CHECK________________________

SKIN__________________________________ MAY THE STUDENT PARTICIPATE IN ALL PHYSICAL ACTIVITY? _____

NEURIOLOGICAL_________________________

EMOTIONAL_____________________________

DENTAL________________________________

NUTRITIONAL ___________________________

PAST ILLNESSES, INCLUDING CONTAGIOUS DISEASES___________________________

OPERATIONS____

SIGNIFICANT FAMILY HISTORY____

SIGNIFICANT CHRONIC PROBLEMS______________________________________

MAINTENANCE MEDICATION____

IMMUNIZATIONS DURING THE PAST YEAR_________________________________

ALLERGIES____

PHYSICIAN'S SIGNATURE________________________________DATE________________

PHYSICIAN'S STAMP____________________________________TELEPHONE____________