

THE BROWNING SCHOOL



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**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: _____