THE DARROW SCHOOL HEALTH RECORD

To be filled out by both Parent/Guardian and Physician

Student's Name	Sex	Grade	Age	Date of Birth

Parents, please fill out the following health history questionnaire completely and accurately.

ALLERGIES:

Does your child have any drug allergies? _________If you answered yes, please specify to which drugs your child is allergic and the reaction caused.____

Does your child have any other allergies? (e.g., environmental, seasonal, food, insect bites, other…) Please specify and indicate type of reaction.

____

MEDICAL/SURGICAL HISTORY:

Please indicate any recent or chronic medical conditions that your child has received medical treatment for: (e.g., Skin conditions, ulcers, asthma, diabetes, epilepsy, scoliosis, tonsillitis, mononucleosis, gallstones, appendicitis, chicken pox, strep throat, fractures, neurological conditions, kidney disease, other….)**Please also indicate any notable family medical history (e.g. diabetes, cancer, heart disease, neurological conditions, gastrointestinal conditions, etc…)

____

Please indicate any surgery your child has had and year performed:____

Please indicate any mental health diagnoses for which your child is or has been treated for (e.g., ADHD, depression, anxiety disorder, bipolar, eating disorder, etc…)and treatment (e.g. counseling, medication, hospitalization, etc..)

____

Please indicate whether your child has any history of substance use (y/n):______ alcohol _______cigarettes/tobacco _______Marijuana ______prescription drug abuse _________other drugs ____________other substances

Please indicate any treatments, evaluations or recommendations made for history of substance use ______________________

Does your child follow a special diet or have any dietary restrictions? If yes, please specify.__________________________

MEDICATIONS:

Please indicate any prescription medications, vitamin supplements and/or herbal supplements your child will be taking while at Darrow School. Medications are administered routinely four times daily at Darrow School; please mark the boxes indicating the times that will work best for your child. For prescription medications, please indicate for what diagnosis it has been prescribed for.

Medication and dosage:	7:30am	11:30am	5:30pm	Bed	**Prescribed For:**

PHYSICIAN INFORMATION:

Please list all physicians, specialists, psychologists, and/or psychiatrists your child sees on a regular basis and/or prescribed medicine for your child. Please include address and telephone number.

1. Primary Physician:____
2. ____
3. ____

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MEDICAL EXAMINATION AND SCREENING
(To be completed by physician)

Doctor: Please fill form in completely. Please also review health history, allergies and medications taken on reverse side of this form and update as needed.

*Screenings must be completed yearly for enrollment in New York State schools.

Vital Signs:	FINDINGS	REMARKS			FINDINGS	REMARKS
Temperature				Eyes		
Pulse				Ears		
Respirations				Lymph Nodes		
Blood Pressure				Thyroid		
Height				Nose		
Weight				Tonsils		
***Vision:**				Teeth		
Without Glasses	R:			Heart		
	L:			Lungs		
	Both:			Abdomen		
With Glasses	R:			Hernia		
	L:			Genitourinary		
	Both:			Skin		
***Hearing:**	R:			Nervous System		
	L:			Musculoskeletal System		
***Scoliosis:**				Nutrition		
Front view				Speech		
Side view				Mental		
Back view				Other Comments:		
Teeth:						
Primary						
Secondary						
Orthodontry				Activity Restrictions:		
Treatment Needed:						

Immunizations: Please see attached form. If you claim are claiming religious or medical exemption from immunizing your child please indicate so on page 2 of immunization form.

This student has been found physically capable of attending The Darrow School and participating in Darrow's athletic program and school activities unless otherwise noted. I have reviewed the medical history form and find it to be complete and accurate to my knowledge.

Date:________________Signature:____

Telephone:_____________________________________Address/Stamp: