

# HEALTH FORM

A completed health form is due at least two weeks prior to your child's enrollment. **Children will not be accepted without a completed health form.** Please use this form if your pediatrician requests a form from the school. Otherwise, we accept the forms that your pediatrician utilizes. Please mail or have your pediatrician mail a completed health and immunization record forms to The Laurel School at 1436 Long Pond Rd, Brewster, MA 02631 or fax to (508) 632-6555.

Name \_\_\_\_\_  
*Last* *First* *Middle*

Home Address \_\_\_\_\_  
*Street Address* *City* *State* *Zip*

Gender:  Male  Female Birth Date \_\_\_\_\_

**ALLERGIES** List all known. Describe reaction and management of the reaction.

**Medication Allergies** (list)

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**Food Allergies** (list)

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**Other Allergies** (list) include insect stings, hay fever, asthma, animal dander, etc.

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**MEDICATIONS BEING TAKEN** - Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Any medications (prescribed or non-prescribed) must be checked in at the office. Keep it in the original packaging/bottle that identifies all medications, the dosage, and the frequency of administration.

This child takes NO medications on a routine basis.

This child takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Name of **Family Physician** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of **Family Dentist/Orthodontist** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Authorization:** This health history is correct and complete as far as I know, and the child herein described has permission to engage in all school activities except as noted.

Guardian/Parent Signed \_\_\_\_\_

Date \_\_\_\_\_

A physician's report of physical examination is required and may be performed any time in the 12 months preceding the admission of the student. Physician must submit an immunization record and this completed form to The Laurel School.

### PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

I have examined the child \_\_\_\_\_ Date of examination \_\_\_\_\_

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

In my opinion, the child  is  is not able to participate in active school programs.

The applicant is under the care of a physician for the following conditions:

\_\_\_\_\_  
\_\_\_\_\_

Current treatment at the time of this report includes:

\_\_\_\_\_  
\_\_\_\_\_

#### Recommendations and Restrictions at school

Treatment to be continued at school:

\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at school (name, dosage, frequency):

\_\_\_\_\_  
\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

Known allergies:

\_\_\_\_\_  
\_\_\_\_\_

Description of any limitation or restriction on school activities:  None  Routine Activities  Competitive Sports  
 Overnights

\_\_\_\_\_  
\_\_\_\_\_

Additional information:

\_\_\_\_\_  
\_\_\_\_\_

#### Signature of Licensed Medical Personnel

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

Please submit immunization record with this completed form.