Mohawk Country Day School

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Please Return by September 2

PARENT AND/OR GUARDIAN MUST COMPLETE and SIGN THIS SIDE OF FORM
ATTACH TO YOUR CHILD'S MOST RECENT PHYSICAL AND IMMUNIZATION RECORD

Child's Name: _____ Date of Birth: _____ Weight: _____

Significant Health History (i.e., diabetes, seizures, heart disease, etc.): _____

_____

_____

Allergies (foods, drugs, plants, insects, etc.): _____

_____

Does your child require an Epi-pen, Auvi-q or other Epinephrine Auto-Injector: Yes* _____ No _____ ***If yes, complete the "Prescription Medication Consent" form.***

Emotional concerns (explain): _____

_____

Operations or serious injuries (explain, with dates): _____

_____

Disability or chronic or recurring illness: _____

_____

Any specific activities to be limited by physician's advice: Yes* _____ No _____ ***If yes, attach letter of explanation.***

Dietary modifications ***(if so, attach letter of explanation)***: _____

Current medication(s)*: _____

Complete the "Medication Consent Form" if your child requires any medication while at school.

Name of Dentist/Orthodontist: _____ Phone No: _____

If we need to reach you or a representative for your child, we will use the emergency contacts you have provided on your child's registration form.

_____ **Date:** _____

Parent Signature

Please attach your child's most recent physical and immunization record.

(OR have your child's physician complete and sign this form and attach immunization record).

Child's Name (*Please Print*): _____ Date Examined: _____

Significant medical history (including seizures, surgeries, loss of consciousness, etc.): _____

_____

_____

Allergies (foods, drugs, plants, insects, etc.): _____

EpiPen, Auvi-q or other Epinephrine auto injector needed? _____ Yes*_____ No ***If yes, complete the "Prescription Medication Consent" form.***

Emotional health concerns (ADD, ADHD, phobias, etc.): _____

_____

_____

Child is under the care of a physician for the following condition (physical and/or behavioral): _____

_____

_____

Current treatment (include current medication): _____

_____

_____

Any prescribed medication to be administered during the day? _____ Yes* _____ No ***If yes, please fill out and sign the "Medication Consent Form."***

Physical restrictions (please describe): _____

_____

_____

MD Name (please print): _____ Phone: _____

MD Signature: _____ Date: _____