

ממבן Maimonides School

Health Office • 2 Clark Road, Brookline, MA 02445
 p 617 232 4452 x406 • f 617 739 8683 • rshuman@maimonides.org

STUDENT HEALTH INFORMATION (TO BE COMPLETED BY PARENT)

Name of Child: _____ Grade: _____ Male Female

Home Address: _____
Street/Apt # City State Zip

Home Phone: _____ Date of Birth: _____ Place of Birth: _____

A recent physician's physical examination of your child and his/her immunization history must be submitted for your child to attend school. Please submit updated physicals for students entering 4th, 7th, and 10th grade.

STUDENT HEALTH HISTORY (Date Filled Out: _____)

Please check below any problems your child has or has ever had, giving approximate dates and details.
 (Additional space on the back of this form may be used.)

DESCRIPTION	DATE/DETAILS	DESCRIPTION	DATE/DETAILS
*Allergies (specify treatment):		Diabetes	
Hay Fever		Frequent Ear Infections	
Severe Ivy Allergy		Frequent Strep Throat	
Insect/Bee Sting Allergy		Tonsillitis	
Medication Allergies		Gastrointestinal	
Food Allergies		Heart Defect/Disease	
*Asthma:		Orthopedic	
Triggers		Seizures/Fainting	
Signs & Symptoms		Skin Conditions	
Treatment		Operations/Serious Injuries	
Skin Conditions		Urinary Tract	
Bleeding/Clotting		Vision/Hearing	

***Please complete asthma & allergy care plans annually** if your child has asthma or severe allergies.
 Forms may be downloaded from www.maimonides.org/health or picked up at one of the health offices.

Can your child **participate in full school activities**, including gym and recess? Yes No

Has child menstruated (for females)? Yes No Any problems? _____

Other medical problems? (Additional space available on back of sheet.) _____

Please list prescription medications (including dosage and time) your child takes at home. _____

Does your child require a nebulizer or epipen? Yes No If yes, please explain. _____

State regulations require that the school nurse administer all medications taken during the academic day. Please list below any prescription medications to be taken at school. (Additional space on the back of this form may be used.)

NAME OF MEDICATION	DOSAGE	TIME

(over, please)

MEDICAL CARE

Family Doctor/Pediatrician/Clinic: _____
Address: _____ Telephone: _____
Dentist/Clinic: _____
Address: _____ Telephone: _____
Special Consultant: _____ Type: _____
Address: _____ Telephone: _____
Health Plan: _____ Subscriber: _____ I.D. #: _____

FAMILY HISTORY

Mother's Name: _____
Daytime Phone: _____ Date of Birth: _____ Place of Birth: _____
Health Problems: _____
Father's Name: _____
Daytime Phone: _____ Date of Birth: _____ Place of Birth: _____
Health Problems: _____

SIBLING'S NAME	GENDER	DATE & PLACE OF BIRTH	SCHOOL & GRADE	HEALTH PROBLEMS

ADDITIONAL INFORMATION

PARENT/GUARDIAN PERMISSION

I give permission for my child to self-administer the following medications when supervised by trained school personnel.

His/her asthma medication: Yes No N/A
His/her own epipen for allergic reactions: Yes No N/A

I give permission to the school nurse to dispense the following medications to my child as needed in accordance with the Standing Orders of the School Physician. (Check only medications you wish to have dispensed.)

Acetaminophen (TYLENOL) Ibuprofen (ADVIL, MOTRIN)
 Diphenhydramine (BENADRYL, FOR ALLERGIC REACTIONS) Tums

To my knowledge, my child has no medical conditions or allergies which contraindicate the use of the medications I have approved.

Signature of Parent/Guardian: _____ Date: _____

I understand that Maimonides School does not perform scoliosis screenings, and I agree to take responsibility for having my child's posture screened by his/her health care provider.

Signature of Parent/Guardian: _____ Date: _____