

THE RIDGE STREET COUNTRY SCHOOL, INC.

MEDICAL INFORMATION FORM (TO BE FILLED OUT BY PHYSICIAN)

431 NORTH RIDGE STREET
 RYE BROOK, NEW YORK 10573
 914-939-5460 • Fax: 914-939-1449
 www.ridgestreetcountryschool.com
 ridgestreetcountryschool@verizon.net

CHILD'S NAME	DATE OF BIRTH	DATE OF EXAMINATION
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The above named child was examined and found to present no hazard from contagious and communicable disease and is in good health.

IMMUNIZATIONS (INCLUDE ALL DATES)					
DPT	1st	2nd	3rd	BOOSTER	BOOSTER
ORAL POLIO	1st	2nd	3rd	BOOSTER	BOOSTER
MEASLES	DATE	RUBELLA	DATE	MUMPS	DATE
LEAD SCREENING	VARICELLA		PNEUMOCOCCAL VACCINE (PCV)		
DATE	DATE	DATE	DATE	DATE	DATE
HEPATITIS B	HJB VACCINE		TUBERCULIN TEST (OPTIONAL)		
DATE	DATE	DATE	TYPE	TYPE	RESULT
GIVE SPECIFICS FOR ALL YES RESPONSES AT RIGHT			SPECIFICS		
1. Are there allergic problems? <input type="checkbox"/> Y <input type="checkbox"/> N					
2. Are there food allergies? <input type="checkbox"/> Y <input type="checkbox"/> N					
3. Are there allergies to drugs? <input type="checkbox"/> Y <input type="checkbox"/> N					
4. Does your child use an Epi-pen? <input type="checkbox"/> Y <input type="checkbox"/> N					
5. Is medication taken regularly? (If yes, specify drug and condition) <input type="checkbox"/> Y <input type="checkbox"/> N					
6. Are there any conditions requiring special attention? <input type="checkbox"/> Y <input type="checkbox"/> N					
7. Are there any food restrictions? (If yes, please specify diet and condition) <input type="checkbox"/> Y <input type="checkbox"/> N					
8. TEETH	CONDITION				
9. HEARING TESTED	DATE	METHOD	RESULT		
10. VISION TESTED	DATE	METHOD	RESULT		
11. MENTAL GROWTH AND DEVELOPMENT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	(IF ABNORMAL, DESCRIBE)			
12. PHYSICAL GROWTH	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	(IF ABNORMAL, DESCRIBE)			
LIST ANY SPECIAL RECOMMENDATIONS CONCERNING CHILD'S HEALTH (use the reverse side if necessary)					
PHYSICIAN'S SIGNATURE			PHYSICIAN'S NAME (PLEASE TYPE OR PRINT)		
ADDRESS			PHYSICIAN'S PHONE		