



Mount Tom Day School

MEDICAL FORM

Please Print Clearly

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Male—Female

Address \_\_\_\_\_ Home # \_\_\_\_\_

City

State

Zip

\*\*\*\*\*

(TO BE COMPLETED BY PHYSICIAN)

Please state any information which will be of significance to us. Include any physical handicap, limitation, special treatment, dietary restrictions, or other pertinent information. State if child is on medication

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

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

Food allergies (list) \_\_\_\_\_  
\_\_\_\_\_

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.  
\_\_\_\_\_  
\_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Date of last tetanus injection \_\_\_\_\_

May child participate in all activities? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_  
Street City, State Zip

IMMUNIZATIONS (Please indicate dates of immunizations.)

DPT	_____	_____	_____	_____
MMR	_____	_____	_____	_____
Polio	_____	_____	_____	_____
HIB	_____	_____	_____	_____
Hep B	_____	_____	_____	_____
Varicella	_____	_____	_____	_____

EMERGENCY TREATMENT CONSENT

I do hereby give authority to The Mount Tom Day School to obtain necessary emergency medical treatment for my child in the event that the parent cannot be reached, with the understanding that the family will be notified as soon as possible.

Signed \_\_\_\_\_  
Parent or Guardian

Please note that according to New York State Education law, we cannot administer over the counter medication to your child.

Prescription medication may only be administered by a parent or guardian. Therefore, if your child is on medication, please administer before school or make arrangements to come in during school, if necessary.