# The Rumson Country Day School
# Physicians Report 2010-2011
# Student Health History - Grades N-4th

Student's Name_______________________________________ Date of Birth:_____________________

Age: _______________ Grade: ___________________________

Significant Past Illness or Injury: ________________________________________________

Varicella Disease: ________________________________________________

Allergies: ________________________________________________

| Vaccine type | Disease Date | 1st Dose Mo/Day/Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/Yr | 4th Dose Mo/Day/Yr | 5th Dose Mo/Day/Yr | Other Mo/Day/Yr |
|---|---|---|---|---|---|---|---|
| Diphtheria, tetanus, pertussis- DTP (If DT or Td, indicate in corner box) | | | | | | | |
| Polio Oral Polio Vaccine (OPV) If Salk, indicate IPV in corner box | | | | | | | |
| Measles, mumps, rubella (MMR) | | | | | | | |
| Measles | | | | | Measles Serology | Date: | Titer: |
| Rubella | | | | | Rubella Serology | Date: | Titer: |
| Mumps | | | | | Mumps Serology | Date: | Titer: |
| Haemophilus B (HIB) | | | | | | | |
| Hepatitis B | | | | | | | |
| Varicella | | | | | | | |
| Other (Specify) | | | | | | | |

**Examination:**

Height:____________ Weight:______________ BP __________________

Eyes: ____________ Vision Tested: Yes_____ No _____ Vision R 20/________L 20/_______Wears Glasses _____

Ears: ____________ Hearing Tested: Yes _____ No _____ Hearing R ________ L ________

Respiratory ______________________________ Cardiovascular ______________________________

Liver ____________ Spleen ________________ Hernia ______________________________

Musculo-Skeletal ___________________________ Skin ______________________________

Scoliosis Screening__________________________ Genitalia______________________________

Neurological ______________________________ Urinalysis performed: Yes _______No __________

Presently taking medication? Yes _____ No ____ If yes, will this be taken during school? __________

If yes, please specify ________________________________________________

Restrictions in Physical Education? Yes ______ No ______ Comments:________________________

________________________________________________

Mantoux TB Test given? Yes ___ No ___ Results________________________________

Signature of Examining Physician: ______________________________ Date _______________

Physician's Address:______________________________ Phone_______________

**The Rumson Country Day School**
**Emergency Procedure Form 2010-2011**

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Student's Name ______________________________________Grade _____DOB ______ Age______

Parent's Name_______________________________ Address _______________________________

City______________________________ State ______ Zip _____

Medical Insurance______________________

Physician's Name_____________________________Telephone _____-_____-_____

Dentist's Name_______________________________Telephone _____-_____-_____

In case of emergency, illness or accident to the child named above, the School is authorized to proceed as indicated below:

**Contact mother at:**
Home Telephone ________________Work Telephone ____________Cell/Car Phone__________

**Contact father at:**
Home Telephone ________________Work Telephone ____________Cell/Car Phone ___________

**Contact relative, neighbor, babysitter or housekeeper at**:
Home Telephone ________________Work Telephone ____________Cell/Car Phone___________

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In the event that any of the above cannot be reached, I hereby authorize The Rumson Country Day School authorities to take appropriate emergency action for the safety of my child, and authorize the School authorities to sign consents for hospital administration and for any emergency operative procedures. Riverview Medical Center is the designated hospital for this area:

Signature of Parent or Guardian: _______________________________ Date: ____________________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

Facts concerning the child's medical history including allergies, daily medications, and any physical impairments to which a physician should be alerted in an emergency should be listed below:

Illness, injury or operation during the past year?____________________________________________

Specify ____________________________________________ Date: ____________________________

Received any immunizations or tests during the past year?

Specify ____________________________________________ Date: ____________________________

Allergic to any medications or foods?____ Specify___________________________________________

Taking any daily medication?

Vision _____________________ Hearing ________________ Orthopedic _____________

Allergies_____________________ Asthma ________________ Epilepsy _____________

Speech _____________________ Heart Disease ____________ Diabetic _____________

Other _________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Please Return to School Office by August 13, 2010.
Anne G. Kerr, R.N., School Nurse

**RUMSON COUNTRY DAY SCHOOL**
35 Bellevue Avenue
Rumson, NJ 07760
www.rcds.org
Telephone: 732-842-0527 FAX: 732-758-6528

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# 2010-2011 MEDICATION PERMISSION FORM

In accordance with the New Jersey Department of Education Guidelines for School Health and the Rumson Country Day School Policy on Administering Medications:

> **"No prescription or over the counter medication will be administered without a written order from the student's physician or licensed prescriber and without a written request by parent or guardian for administration"**

All medications must be sent to the school in the original container accompanied by the physician's written request.

Name of Student__________________________________________ Date:__________________

Name of medication:_____________________________________________________________

Dose/route/frequency: ____________________________________________________________

Instructions regarding administration: _______________________________________________

_______________________________________________________________________________

Physician/Health Practitioner signature: _____________________________________________

Parent/Guardian Signature: _______________________________________________________