Yavneh Academy Health Form
Completed by Health Care Provider

Grade as of 09/01/2017_____ Age as of 09/01/2017_____ Date of Last Exam: _____

Name of Student: _____D.O.B: _____

Address: _____ Tel #: _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

Vision: R 20/_____ L 20/_____ Corrected: Y / N Hearing: Left_____dcb Right_____dcb

Scoliosis: ❒ Negative ❒ Positive

Are there any medical issues past or present? : ❒ No ❒ Yes _____

_____

Are there any activities from which student should be limited?* ❒ Yes ❒ No _____

_____

Does the student take any prescribed medications: ❒ No ❒Yes _____
(Name and dosage of all medications)

_____

Does the student have any allergies?* ❒ No ❒ Yes _____

***Attach detailed reports if necessary (i.e. Asthma/ Allergy Action Plan or Prescriptions)*

Please be advised that no medications – Prescribed and non-prescribed (OTC) – can be administered without consent from your child's physician and a parent. Both signatures are required (parent and physician). Should you anticipate your child requiring an over the counter medication such as an Acetaminophen, Ibuprofen, Antihistamine, Tums, etc., please have your physician fill out the consent form below.

❒ Check here if you do NOT want your child to receive ANY medications at school.

Please circle yes or no:

Acetaminophen	325mg for pain or fever. 1 or 2 tablets, 6-12 years; liquid per age/weight. May be repeated in 4 hours as needed	Yes	No
Ibuprofen	200mg for pain or menstrual cramps. 1to 2 tablets; liquid per age/weight. May repeat 4 to 6 hours as needed	Yes	No
Benadryl	25mg-50mg for acute allergic reactions. ONLY 1-2 tabs/ 1-2 tsp liquid	Yes	No
Tums	1-2 tablets as needed for indigestion (for children in third grade and above).	Yes	No
Cough Drops	Lozenge as needed for cough/sore throat (for children in third grade and above).	Yes	No

I authorize the school nurse to administer the above medications to: _____
(Name of Child)

BOTH signatures are required**

Parent's Signature: _____ Date: _____**

Physician's Signature (or MD stamp) **: _____ Date: _____

******PLEASE ATTACH IMMUNIZATION RECORD******