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
info@ridgestreetcountryschool.com

CHILD'S NAME	DATE OF BIRTH	DATE OF EXAMINATION

☐ 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
HEPATITIS B	**HIB VACCINE**	**TUBERCULIN TEST (OPTIONAL)**
DATE	DATE	TYPE RESULT

GIVE SPECIFICS FOR ALL **YES** RESPONSES AT RIGHT		**SPECIFICS**
1. Are there allergic problems?	☐**Y** ☐N	
2. Are there food allergies?	☐**Y** ☐N	
3. Are there allergies to drugs?	☐**Y** ☐N	
4. Does your child use an Epi-pen?	☐**Y** ☐N	
5. Is medication taken regularly? (If yes, specify drug and condition)	☐**Y** ☐N	
6. Are there any conditions requiring special attention?	☐**Y** ☐N	
7. Are there any food restrictions? (If yes, please specify diet and condition)	☐**Y** ☐N	

8. TEETH	CONDITION		
9. HEARING TESTED	DATE	METHOD	RESULT
10. VISION TESTED	DATE	METHOD	RESULT
11. MENTAL GROWTH AND DEVELOPMENT	☐ Normal ☐ Abnormal	(IF ABNORMAL, DESCRIBE)	
12. PHYSICAL GROWTH	☐ Normal ☐ 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