Academies at Gerrard Berman Day School

2017-2018

Student Name ______________________	**DOB**______________	**M/F** ______
Address ______________________		
Physician's Name ______________________	**Phone Number** ______________	**Chart #** __________

* IMMUNIZATIONS –Please *attach current immunization record*

MEDICAL HISTORY (to be completed and signed by doctor)

Date of Last Physical Exam ____________		**(based on a physical performed within the past 12 months)**
Height ____________	**Weight** ____________	**Vision** ____________ **(pass/refer)**
B/P ____________	**Pulse** ______	**Hearing**____________ **(pass/refer)**

Medical Condition(s)

Allergies – (attach current Allergy Action Plan, if applicable)

Medication(s) ______________________________

Food ______________________________

Other ______________________________

Medication(s) currently prescribed/use – (attach current Asthma Treatment Plan OR Epi Pen Care Plan, if applicable)

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Activity Restrictions ______________________________

Other ______________________________

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Physician's signature/date ______________________________

***Please return this form to:**
Gerrard Berman Day School, School Nurse, 45 Spruce Street, Oakland, NJ 07436
FAX# 201-337-7795