ACADEMIES AT GERRARD BERMAN DAY SCHOOL

Health Services

Dear Parent and/or Guardian

As part of the GBDS Health Program, it is recommended that your child has an annual physical examination by your family physician (Pediatrician). However, the policy in our School **requires** that all new students and those students entering grades K, 3, and 6 have a current physical examination.

Your physician's knowledge of your child makes him/her best qualified to interpret the information necessary to improve the child's health. The family physician can assist the School in making adjustments in the educational program for your child.

A medical examination performed during the summer or within the past 365 days is acceptable. The appropriate forms are attached which can be completed by your family physician.

Please indicate your intention below and return this form to the School Nurse by the first day of school. The **required** physical examination forms must be received by the School before September 2, 2015.

In addition, "Consent for Medication" must be submitted to the School for every student. An explanation and directions are written on this form.

School Health Services

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Student Name ____________________________________ Grade________________________

_______1. The required medical exam was performed by Dr. ___________________________
on _______________________ (date)

_______2. The required medical exam will be performed by Dr. ________________________
on or about ______________________ (date)

_____________________________________ _______________________________
Signature of Parent Print Parent Name

Academies at Gerrard Berman Day School

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

*** IMMUNIZATIONS – *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