bluebrook
medical evaluation form

bluebrook

Please Print Only

All sections of this form must be completed and returned along with your child's enrollment application.

Child's Full Name: ________________________________ Date of Birth: __________Sex: M F

Mother's Name: ___________________________ Father's Name: __________________________________

this section must be completed by the child's personal physician.

immunization status physical examination:

Height: ____________________ Weight: _____________ BP:__________/______

Posture: ____________ Hair: _______________ Skin: _______________

Ears: _______________ Nose: ______________ Throat:_____________

Gums: ______________ Tongue:_____________ Neck: ______________

Abdomen: __________ Reflexes: ___________ Deformities: ________

Lungs: ____________________ Heart: ______________ Genitals ____________

medical history

Immunizations	1st	2nd	3rd	1st Booster	2nd Booster
D.P.T.					
Polio					
M.M.R.					
HIB Vaccine					
B.C.G					
DTap					
Hepatitus B					
Varicella					
Covid19 Vaccine					

	Yes	No		Yes	No		Yes	No
Seizures			Sickle Cell			Asthma		
Tonsilitis			Fainting Spells			Hepatitis		
Skin Problems			Pneumonia			Tuberculosis		
Diabetes			Chicken Pox			Worms		
AD/HD			H.I.V /A.I.D.S			Cancer		
Hearing Problems			Leukemia			Meningitis		
Vision Problems			Heart Problems					

Is the child allergic to anything or any medications? ☐ Yes ☐ No

If yes, please indicate the items to which the child is allergic: ______________________________

____

The child's general health status can be described as: ☐ Excellent ☐ Good ☐ Poor

Is this child physically fit for physical education classes? ☐ Yes ☐ No

Please list any physical education restrictions the child may have: ______________________________

____

Is the child under special medical care? ☐ Yes ☐ No

If yes, please share the details of the care being administered: ______________________________

____

Please list any surgeries and approximate medications the child is currently on:

______________________________ ______________________________

______________________________ ______________________________

Is the child experiencing any developmental delays/learning differences that the school should be aware of?

☐ Yes ☐ No If yes, please state below: ______________________________

____

Physician's Signature: ______________________________

Physician's Office Stamp Here:

this section must be completed by the child's parent /guardian

How is your child's behavior best described?

☐ Socially well-adjusted ☐ shy or withdrawn ☐ fights/hits/bites

Does your child have any emotional issues that the school should be aware of? ☐ Yes ☐ No

If yes, please explain: ____

____

insurance information

Is your child covered by health insurance: ☐ Yes ☐ No

If yes, please provide the name of insurance company: ______________________

Group Insurance No.______________ Individual Insurance No. ______________

The name of the child's Primary Care Physician ______________________

in case of an emergency

Please provide a minimum of (3) three Emergency Contacts (other than the child's parents):
Please list the contacts with the most desired to the top and the others falling beneath it.

First Name: ______________________ **Last Name:** ______________________

Relationship to child: ______________________

Please list a minimum of (2) contact numbers for this individual:

______________________ ______________________

First Name: ______________________ **Last Name:** ______________________

Relationship to child: ______________________

Please list a minimum of (2) contact numbers for this individual:

______________________ ______________________

First Name: ______________________ **Last Name:** ______________________

Relationship to child: ______________________

Please list a minimum of (2) contact numbers for this individual:

______________________ ______________________

In the event of an emergency where hospital care is deemed necessary and where I cannot be reached, Bluebrook hereby receives my consent to have my child taken to:

Doctor's Hospital ☐ Princess Margaret Hospital ☐

and to provide any emergency care deemed necessary for my child. I further authorize the transfer of my child's health records to the hospital indicated above.

In the event of an emergency requiring first aid to be administered to save my child's life, I authorize the CPR certified staff of Bluebrook to conduct first aid procedure/s deemed necessary for my child until such time as a paramedic arrives or my child arrives to hospital.

Does your family have religious restrictions as it pertains to medical care? ☐ Yes ☐ No

If yes, please provide details: ____

____

Signing Parent/ Guardian's Full Name: ____

Parent's Signature: ____Date ______________________

Please return this copy both completed and signed to Bluebrook's Administration Office along with other enrollment requirements.

thankyou!