Mary McDowell Friends School

20 Bergen Street • Brooklyn • New York 11201 • (718) 625-3939

2011-2012 CONTACT INFORMATION FORM

(Please print all information)

Please provide us with contact information for the 2011-12 school year by completing the form below.

Name of Student: ______________________________

Parent/Guardian 1

Name 1: ______________________________

Name 2: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Home #: ______________________________

Name 1 Work: ______________________________

Name 1 Cell: ______________________________

Name 1 Email: ______________________________

Name 2 Work: ______________________________

Name 2 Cell: ______________________________

Name 2 Email: ______________________________

Parent/Guardian 2

Name 1: ______________________________

Name 2: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Home #: ______________________________

Name 1 Work: ______________________________

Name 1 Cell: ______________________________

Name 1 Email: ______________________________

continued →

Name 2 Work: ____________________

Name 2 Cell: ____________________

Name 2 Email: ____________________

continued →

Mary McDowell Friends School

REPORT ON PHYSICAL EXAMINATION

2011-2012 Academic Year

NAME OF CHILD: ______________________ **DATE OF BIRTH** ____________
Please print

Well Child ☐ Yes ☐ No
If no, please explain: ____

Chronic Illnesses: Asthma ☐ Yes ☐ No Other: ______________________
Allergies: ☐ Yes ☐ No ______________________

	Normal	Abnormal		Normal	Abnormal
General	☐	☐	Heart	☐	☐
HEENT	☐	☐	Extremities	☐	☐
Chest	☐	☐			

Height ________ **Weight** _____ **BMI** _____ **Hearing** **L** _____ **R** ______

Vision Without glasses: R 20/______ L 20/______
With glasses/lenses: R 20/______ L 20/______ Color Vision ____________

Hemoglobin Test: *(if indicated)* GMS ________ BP ______________
Annual urinalysis *(required)* Sugar ________ Albumin ________ Microscopic _____
Scoliosis screening *(requested)*
Mantoux, PPD Implant ________ Reading: ________ Negative ☐ Positive ☐ Size _____ mm
Date *Date*

Note: NYC DOE requires a Mantoux for all students entering any secondary school.

Does this student have a **health condition** that may require emergency action while in school or which might impact on functioning in school *(e.g. seizures, bleeding problems, diabetes, heart problems, asthma).?* ☐ Yes ☐ No
If yes, please describe:

Does this student have any **allergies** *(insect bites/stings, drugs, dust, animals, food etc.) ?* ☐ Yes ☐ No
If yes, please describe:

Does the student have any **dietary restrictions**? ☐ Yes ☐ No
Does the student take any **dietary supplements**? ☐ Yes ☐ No
If there are dietary restrictions or supplements, please describe: ______________________

Is this student capableof unlimited participation in the athletic program? ☐ Yes ☐ No
Is this student capable of participating in occupational therapy for this school year? ☐ Yes ☐ No

For grades K - 5 a prescription for occupational therapy must be submitted with this form

The student may be given the following medication: Benadryl ☐ Yes ☐ No
Ibuprofen (Advil) ☐ Yes ☐ No Acetaminophen (Childrens Tylenol) ☐ Yes ☐ No None

Physician's signature:______________________________ Date: ________________

IMMUNIZATION HISTORY

Is this child exempt from immunization? ❒ Yes ❒ No

If yes - what is the reason? Medical ❒ Religious ❒

If exempted, documentation must be attached to this form

DPT/DTaP/DTTD or Tdap	*Date*	*Date*	*Date*	*Date*	*Date*
Polio/PV	*Date*	*Date*	*Date*	*Date*	*Date*
Measles	*Date*	*Date*			
Mumps	*Date*	*Date*			
Rubella	*Date*	*Date*			
Tetanus	*Date*	*Date*	*Date*	*Date*	*Date*
HB (hepatitis B)	*Date*	*Date*	*Date*	*Date*	*Date*
HIB	*Date*	*Date*	*Date*		
Varicella	*Date*				
Menactra	*Date*				
Menomune	*Date*				
Other	*Type*	*Date*		*Type*	*Date*

* ***When appropriate medical documentation indicates that the student had the disease, write in M.D.DX*** *(medically documented disease history).* **Documentation must be attached.**

Date of examination		
Physician Name		
Physician's Signature		
Phone number		Physicians Stamp
Address		

Mary McDowell Friends School

MEDICATION INFORMATION & CONSENT FORM

2011-2012 Academic Year

NAME OF CHILD ____________________________________ DATE OF BIRTH________
—

NOTE: This form must be signed by both a physician and student's parents

- *For your child's safety it is important for the School to know all the medications that your child is taking, and if staff are permitted to administer medications to your child in school and on school organized overnight trips. A new form must be completed every time you change medication or modify the dosage.*
- *Please notify the school office if you require an additional form.*
- *This form must be completed and returned to the school nurse, even if your child is not taking any medication.*
- *This information will also be used for overnight trips.*
- *If there are any changes it is the parent's responsibility to submit a new form with both a parent and a physician's signature.*

INDICATE BELOW IF YOU GIVE THE SCHOOL PEMISSION TO ADMINISTER THE FOLLOWING DOCTOR PRESCRIBED MEDICATION:
(Check the appropriate box)

EPIPEN	❒ Yes ❒ No	

INDICATE BELOW IF YOU GIVE THE SCHOOL PERMISSION TO ADMINISTER THE FOLLOWING OVER THE COUNTER MEDICATION:
(Check the appropriate box)

Antihistamines (including Benadryl) in Pill/Liquid Form	❒ Yes ❒ No	Tylenol/Advil	❒ Yes ❒ No
Antihistamine Nasal Sprays	❒ Yes ❒ No	Corticosteroid Nasal Sprays	❒ Yes ❒ No
Antihistamine eye drops	❒ Yes ❒ No		

Special instructions:

My child is NOT taking ANY Medications ❒

My child IS taking the following medications:

Name of medication	*dose*	*time/s of day given*
Name of medication	*dose*	*time/s of day given*
Name of medication	*dose*	*time/s of day given*

THE SCHOOL HAS PERMISSION TO ADMINISTER THE ABOVE MEDICATIONS ON AN OVERNIGHT TRIP ❒ Yes ❒ No

THE SCHOOL HAS PERMISSION TO ADMINISTER THESE MEDICATIONS IN A TIME OF CRISIS ❒ Yes ❒ No

Parent's Name		*Physician's Name*
Parent's Signature	*Physician's Stamp*	*Physician's Signature*
Date		*Date*

Turn over if in school medication request needed

Request for Administration of Medication During the School Day

In order to administer medication to your child during the school day we need:
From you -
- *Your permission*

From the attending physician:
- *Detailed instructions which are signed*
- *Advice as to any possible side effects or indications that the medication should be withheld*
- *The proper procedure should there be an emergency related to the medication.*

We will make every reasonable effort to comply with this request.

Medication name	*Dose*	*Time given*
Medication name	*Dose*	*Time given*
Medication name	*Dose*	*Time given*

I give the School permission to administer the Doctor prescribed medication to my child during the school day as listed about:

Parent Name *Parent Signature* *Date*

Side Effects

Procedures in a medication related emergency:

I request that the School administer the medication prescribed above:

Physician's Name *Physician's Signature* *Date*

Physician's Stamp

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2011-2012 GOING HOME AND EMERGENCY INFORMATION FORM

(Please print all information)

Name of Student: ____

My Child Will Go Home By: (check one)

The School will dismiss your child at the end of each school day according to the information you provide in this form. Any time this information is changed, you must notify the School immediately—even if the change is only for 1 day. In addition, dismissal changes must be given to the School, by note or by phone, by 1 p.m. (12 noon on Wednesdays).

[ ] **Taking a school bus**

[ ] **Being picked up by:** ____, ___________________________
(Name of Person) (Relationship to Child)

[ ] **Walking home/to subway by self**

[ ] **Other:** ____

If you have a bus and need to arrange an alternative drop off, please contact me for the form and/or more information.

Emergency Information:

A. If your child becomes **ill** during the school day, and you cannot be reached, please indicate who should be called to pick up your child.

1. ____, ___________________________, ___________________________
(Name of Person) (Relationship) (Phone #)

2. ____, ___________________________, ___________________________
(Name of Person) (Relationship) (Phone #)

B. In an **emergency** situation when your child cannot go home via the regular dismissal arrangement and you cannot come to the school to get him/her, the school will send your child home with a local MMCL parent.

If you have a specific MMCL parent that you would like your child to go home with, please print his/her information below. The school will try to accommodate your request. However, if it does not work out, your child will be sent home with another local MMCL parent.

Name: ____ Phone #: ___________________________

Parent of: ____ Room: ___________________________

The information on this form must be updated every year. Please be sure to list someone who is available in case of an emergency and be sure to inform the emergency contact(s) that they are listed as an emergency reference for your child and may be called when necessary.

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2011-2012 Academic Year

EMERGENCY CONSENT & PERMISSIONS

Child's Name: ____

1) In the event that I cannot be contacted, I authorize the school administration to designate a doctor and/or hospital to initiate appropriate emergency medical services for my child.

2) I hereby give my consent for my child to practice for, and participate in, all competitive games and contests, except for those listed below:

____

____

PERMISSION FOR EVALUATIONS, PHOTOGRAPHS AND SCHOOL TRIPS

1) The Mary McDowell Friends School staff has permission to perform Psycho-educational, Occupational Therapy and/or Speech and Language Evaluations on my child.

2) I give permission to have my child photographed/video taped as he/she participates in the Mary McDowell Center's program. I also give permission to have samples of his/her work used as examples of the work the children do in the program. These materials will only be used for activities related to the Mary McDowell Center or other training and will not be used for commercial purposes. I understand that these photographs/videos may be used for the school website, brochures, and all other school-related multimedia publications.

3) My child has permission to participate in all trips during the current school year. My child will be walking and taking various forms of public transportation under adult supervision.

Parent's Signature: ______________________________ Date: ______________

Parent's Name: ______________________________
(Please print)

Diversity Survey

Each year we must fill out forms for New York State as to the racial and ethnic makeup of our student body. To help us accurately reflect the diversity of our students, we ask that you complete the questionnaire below.

Child's Name____

Is you child a citizen of the United States?____

If not, in what country does he or she hold citizenship?______________________________

Does your child have dual citizenship?____

If so, in what other country does your child have citizenship?_________________________

Please check your child's racial or ethnic identity—you may check more than one.

_______African American (African or Caribbean ancestry)

_______American Indian (American Indian, Eskimo, or Aleut ancestry)

_______Asian American (China, Japan, Korea, Philippines, Thailand, Cambodia, Laos, Vietnam, India, or Pacific Island ancestry)

_______Latino or Hispanic (Puerto Rican, Cuban, Mexican, Dominican, or Latin or South American)

______Caucasian (not Hispanic)

______Middle Eastern

______Other. My child's racial or ethnic identification is______________________________

_____________________________ _______________________
Signature Date

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2011-2012 Academic Year

Dental Health Certificate

Section 1. To be completed by Parent or Guardian (Please Print)

Name of Child ____**Date of Birth** ________
(please print)

Sex: M__ F__ Grade_____ Will this be your child's first visit to a dentist? Yes__ No__

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes__ No__

Section 2. To be completed by the Dentist

____

Student's Name **Date**

Yes___ No ___ The student listed above is in fit condition of dental health to permit his/her attendance to school.

Dentist's Name and address (Please print or stamp) Date

____

The date of exam needs to be within 12 months of the start of the school year in which it is requested.

____

Dentist's Signature

Summer 2011

Mary McDowell Friends School
Parent / Guardian Information

All Parents/Guardians: please complete this form and return it with your other paperwork.

Please help us keep accurate records by providing the following information:

Parent /Guardian Name ____

Title ____

Occupation____

Employer ____

Areas of Expertise ____

Work Phone ____

Cell Phone ____

Email ____

Parent /Guardian Name ____

Title ____

Occupation ____

Employer ____

Areas of Expertise ____

Work Phone ____

Cell Phone ____

Email ____

over-------→→→

Reaching out to your friends and family will expand the Mary McDowell Friends School community and assist us in deepening our resources. We thank you for sharing friends and family contact information and their potential areas of interest and support:

____

____

____

____

____

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Support Services Form
2011-2012

In order to update our records, we would appreciate your filling out this form based on the outside support services your child received during the summer of 2011 or is planned for the school year of 2011-12. Please fill out this form—even if your child gets no additional supports or if you did so once before—and return it to us as soon as possible.

Thank you for your time and attention.

Deborah Edel
School Psychologist

Name of Child: ______________________________ **Date:** ____________

[ ] No Additional Services

Speech/Language

[ ] On going [ ] Summer only [ ] Other ______________________________

Provider: Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

How many sessions per week? ______________________________

Occupational Therapy

[ ] On going [ ] Summer only [ ] Other ______________________________

Provider: Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

How many sessions per week? ______________________________

Psychotherapy/Counseling

[ ] On going [ ] Other: ______________________________

Provider: Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

How many sessions per week? ______________________________

Tutoring:

[ ] On going [ ] Summer only [ ] Other ______________________________

Provider: Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

How many sessions per week? ______________________________

Medicating Psychiatrist/Neurologist:

[ ] On going [ ] Evaluation only

Provider: Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

How often? ______________________________

Other: ______________________________

____

____

____

I give the Mary McDowell Friends School permission to contact all service providers listed on this form and exchange information that will be beneficial to the school and the therapist(s) in order to help my child.

Signature: ______________________________ Date: ____________________

Name: ______________________________ Relationship: ____________________